R.N.

A JOURNAL FOR NURSES

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Convalescent Care

Nurses through the
Centuries

When she chooses
Natural Childbirth

February 1956

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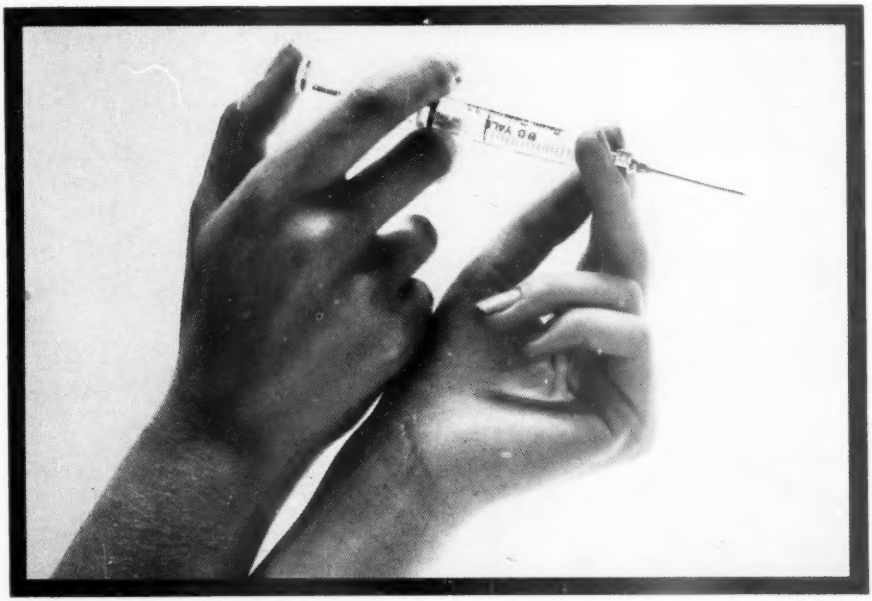

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A JOURNAL R.N. FOR NURSES

VOLUME XIX · NUMBER II · FEBRUARY 1956

CONTENTS

BPA NBP

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ABOUT THE COVER

THE Brooklyn Hospital School of Nursing in Brooklyn, N.Y. has just passed its 75th anniversary year. Organized in 1880 by the ladies of the Flower and Fruit Charity, the school is now an integral part of a general, voluntary 404-bed institution.

Like other old, established schools of nursing, the Brooklyn school has changed its curriculum considerably over the years. In the original two-year course, the first year was spent in study and practice on the wards with instruction given at the bedside by the superintendent of nurses. During the second year, students did private duty nursing to repay the hospital for their education.

Today, The Brooklyn Hospital School of Nursing offers a three-year program of theoretical and clinical instruction with practical experience in the usual hospital departments and affiliations in psychiatric and tuberculosis nursing.

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not all prenatal supplements increase blood calcium levels

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References: 1. Illinois M. J. *105*:305 (June) 1954. 2. Obstet. & Gynec. *1*:94 (Jan.) 1953. 3. Bull. Margaret Hague Maternity Hosp. *6*:107 (Dec.) 1953. 4. Missouri Med. *51*:727 (Sept.) 1954. 5. J. Michigan State M. Soc. *53*:862 (Aug.) 1954.

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TL'S

Dear Editor:

R.N. is one magazine I never intend to let the subscription run out on. It has helped me in many ways during my nursing career. I am one of the "older" nurses, and your small but powerful journal helps me keep up with the fast-moving medical world.

Thank you, and may R.N. never end.

(Mrs.) LOUISE COOPER, R.N.
LEESBURG, FLA.

ACTIVELY INACTIVE

Dear Editor:

A word of thanks for two informative articles: "Insecticide Hazards" (June issue) and "Now I've Had Industrial Experience" (July). The R.N. who wrote the industrial story is surely doing her bit to keep us all encouraged and doing our best whether we are active or inactive.

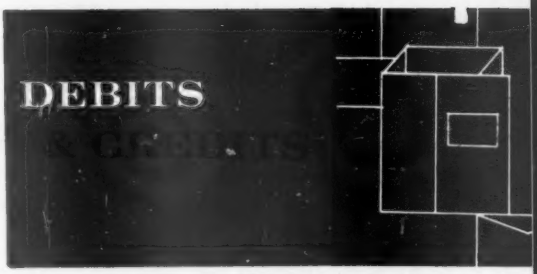
About the word "inactive": Another nurse and I laughed and laughed over your article about the married R.N. who, like ourselves, was so classified. In our case, too, the classification is ironic, for we both are pretty busy keeping our husbands' offices supplied with clean linen, looking after our children, and so on.

R.N., GUATEMALA, C.A.

ILEOSTOMY AID

Dear Editor:

As your magazine contains much that is of practical value to me as a private duty nurse, it occurred to me that your readers might find



the following suggestion helpful.

I have found Saran Wrap of great value on a surgical case. I used this cellophane-like wrapping material to protect the patient's skin from the drainage of an ileostomy. I covered the entire abdomen with Saran Wrap—closing any leakage around the opening over the ileostomy by applying narrow strips of Vaseline gauze before the application of a colostomy dressing. This, of course, was only a temporary treatment until a mechanical appliance was obtained.

EDITH M. PINKHAM, R.N.
WATERVILLE, MAINE

"DO UNTO OTHERS . . ."

Dear Editor:

Thank God for such nurses as Janet M. Geister. Her article, "Nursing's Abundant Challenges" in your November issue, was beautiful—a plea and a prayer. For me, in particular, it provided an answer to a question asked by my young niece: "Wouldn't I *know*," she asked, "if I wanted to be a nurse?" I have given her this article to read, and I'm sure it will answer her question.

Last year, while caring for an aged lady who couldn't speak a

word, I found that we could converse with our eyes and hands. At first I tried to do the talking for both of us; but when this seemed to make her more conscious of her speechlessness, and caused her to cry, I tried to be more observant, asking myself, "What would I want or need if the situation were reversed?"

If we asked ourselves that question more often, how differently we might act toward patients!

(Mrs.) Ila Banbury, R.N.
TOLEDO, OHIO

AN OPPORTUNITY

Dear Editor:

Hurrah for Ruth Johnston's outright indictment of the "profit-hungry hospitals" that are creating the alleged nurse shortage! (*D & C, R.N.*, Nov. 1955). If hospitals are so desperately in need of R.N.'s as they lead the world to believe, they could adjust the working hours so that a married nurse with children could work. In my own case, they wouldn't; I tried and tried to find a general duty position, but none would adjust their schedules an hour or two in either direction.

Two months ago, I found a bedside nursing position—but not in a hospital. I am the only R.N. in a 41 patient rest home; aides and practical nurses comprise the rest of the staff. I not only have hours that fit my home life, but receive all my meals (wonderful home-cooking) and coffee-breaks during my 8-hour day. Most important of

no need to be

A W O L

By using TAMPAX intravaginal tampons, women in all walks of life usually find they can pursue their normal activities without interruption. The greater comfort, convenience, and safety of this improved method of menstrual hygiene has won the enthusiastic approval of nurses everywhere. Physicians too have found it highly satisfactory. The three TAMPAX absorbencies—Regular, Super, and Junior—provide individualized protection to meet varied absorption requirements.

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all, I work at the bedside, doing the kind of nursing I want to do—not supervising or sitting at a desk. I was most reluctant to work in a rest home; but after one day on the job, I came home simply thrilled. It is challenging and gratifying work, and I'm happy to know that there is still one niche in the world where an R.N. can do honest-to-goodness bedside nursing.

KATE JANEKE, R.N.
DES PLAINES, ILL.

THEY'LL RISK IT

Dear Editor:

Three cheers for Christine Newman's letter deploring the stress on malpractice insurance (R.N., November). Let's not continue to be fooled by these appeals of insurance companies.

MARIE DELPINO, R.N.
SANTA MONICA, CALIF.

* * *

Dear Editor:

I'll "risk it" with Christine Newman. From the first, the idea of malpractice insurance struck a discordant note with me. We continue to believe that we can buy security. Have we forgotten the message engraved on our coins, "In God We Trust"? If I give my best to my job, leaving results to universal laws of justice, what do I need to fear?

My belief is that the numerous kinds of insurance we burden ourselves with constitute but another indication of our materialism—and a consequent lack of inner poise. As the late President Roose-

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*Breakey, R. S.; Holt, S. H., and Siegel, D.: J. Michigan M. Soc. 64:805, 1965.

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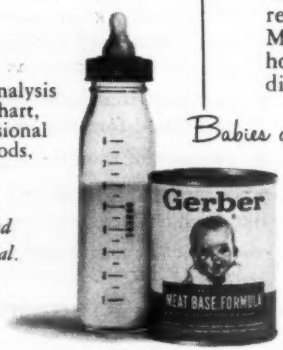
**Rowe, Albert, Jr., M.D., and Rowe, Albert H., M.D.: Cal. Med. 81:279 (Oct.) 1954*



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velt put it, "The only thing we have to fear is fear itself."

BERTHA BAGWELL, R.N.
SANTA CRUZ, CALIF.

* * *

Dear Editor:

The very word "malpractice" is insulting—at least to those of us who live under the influence of the Spanish language. The prefix "mal" suggests either insult or doom in Spanish (depending on its intonation). Thus "malpractice" in our part of the country implies that a nurse maliciously mistreats her patients. None of us denies that accidents can happen; but most nursing accidents are born of overwork—not of neglect.

At a district meeting here, the speaker, a high-ranking Army officer who is also the assistant dean of a university law school, said he saw no reason why nurses should take out such insurance. He said that damage suits are often instituted because people know that the insurance company (not the nurse) will have to pay if the suit is successful; that they would not bother to sue except for knowledge of this fact.

FLORA MURRAY, R.N.
SAN ANTONIO, TEX.

NOVEMBER'S "IDEA"

Dear Editor:

I must tell you how very much I enjoyed Helen Murphy Donovan's Idea-of-the-Month article ("What's the Matter With Us?") in your November issue. I am in complete agreement with its factual presen-

tation, and I hope its stimulating views will be put into practice at all nursing agencies, hospitals, training schools, and universities. I agree that "We are woefully inadequate in the matter of total care"—meaning physical, emotional, social, and spiritual care—and that "Until we are willing to admit this inadequacy, we will continue to criticize our colleagues instead of upgrading the quality of the service for which we are personally responsible."

SYLVIA BEHR, R.N.
NEW YORK, N.Y.

"BRIEF ME"

Dear Editor:

I treasure each issue of R.N. and I can't begin to tell you how often it solves some current problem for me. So I'm hoping you can set me straight on still another problem—one concerning diet in disease.

Twenty years ago I knew diets with the best of them—and still do. I'm perplexed, however, by current dietary rules for ulcer patients and diabetics.

A duodenal ulcer patient told me that when he asked his doctor what scraped beef is, the M.D. said he was "unfamiliar with the term." Yet the term was listed on the mimeographed food-list he had given the patient. (The M.D. is a young associate in a very reputable clinic.) I know what scraped beef is, but I'm wholly unable to reconcile what seem to be grave incon-

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sistencies on that list of "can" and "can't" foods. Hence, I believe that a little discussion and briefing on the modern treatment of ulcers would be valuable to all nurses.

My confusion about diabetic diets results from the fact that I've seen patients receiving trays containing pears, bread (two slices), and other foods that were considered "dynamite" for the diabetic in my time. When I asked a dietitian about these trays, thinking there might have been a mistake, she told me that the feeding of diabetics had undergone a great change. All I can say is "Brief me"!

EDNA P. DAVIS, R.N.
EL PASO, TEX.

[*As this perplexed R.N. has discovered, the science of dietetics has kept pace with the rapid march of medicine, and there have been many changes in both fields over a 20-year period. In some respects, too, the dietary treatment of diabetes and ulcers is still controversial. An excellent dietary refresher reference for nurses is* Nutrition in Health and Disease *by Cooper, Barber, Mitchell, and Rynbergen (J. B. Lippincott Co., Philadelphia).* R.N. *has also published several articles on diet and these specific diseases: "The Ulcer Age" (Sept., 1950); "A Guide to Dietetic Aids" (July, 1954); "Diabetes" (Feb., 1952); and "The Nurse Has Diabetes" (Aug., 1955). Another good source is the American Diabetes Association, 1 East 45th St., New York, N.Y.*—THE EDITORS]

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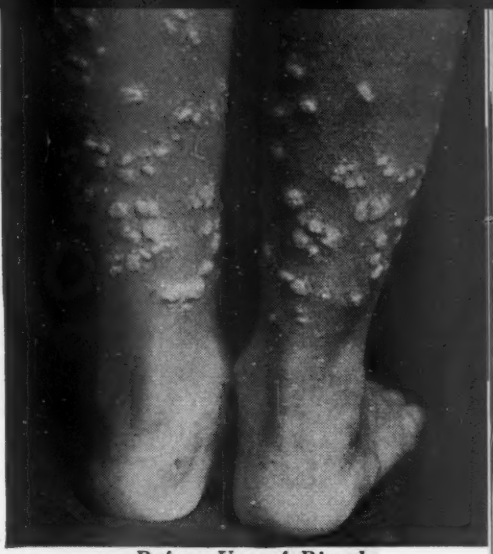

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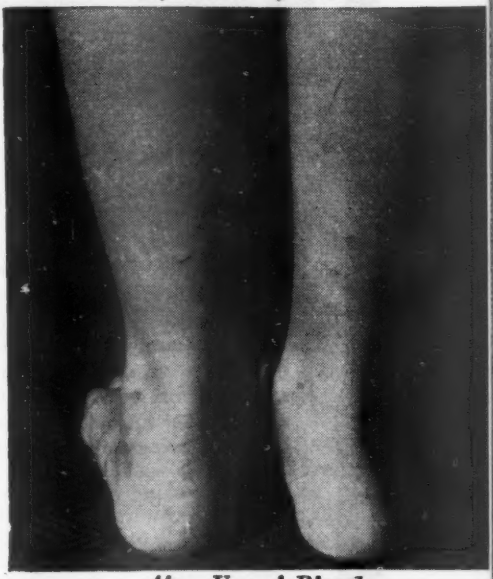

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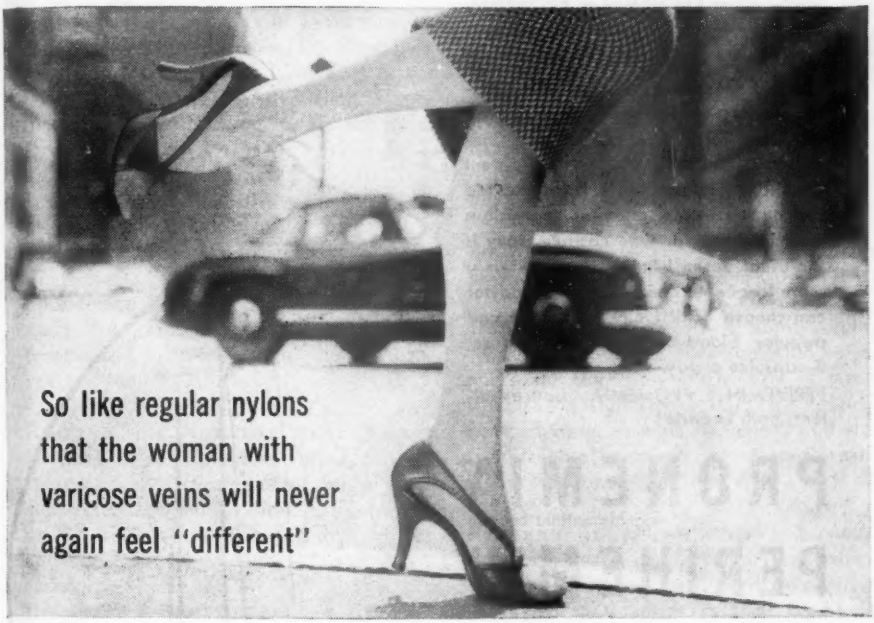

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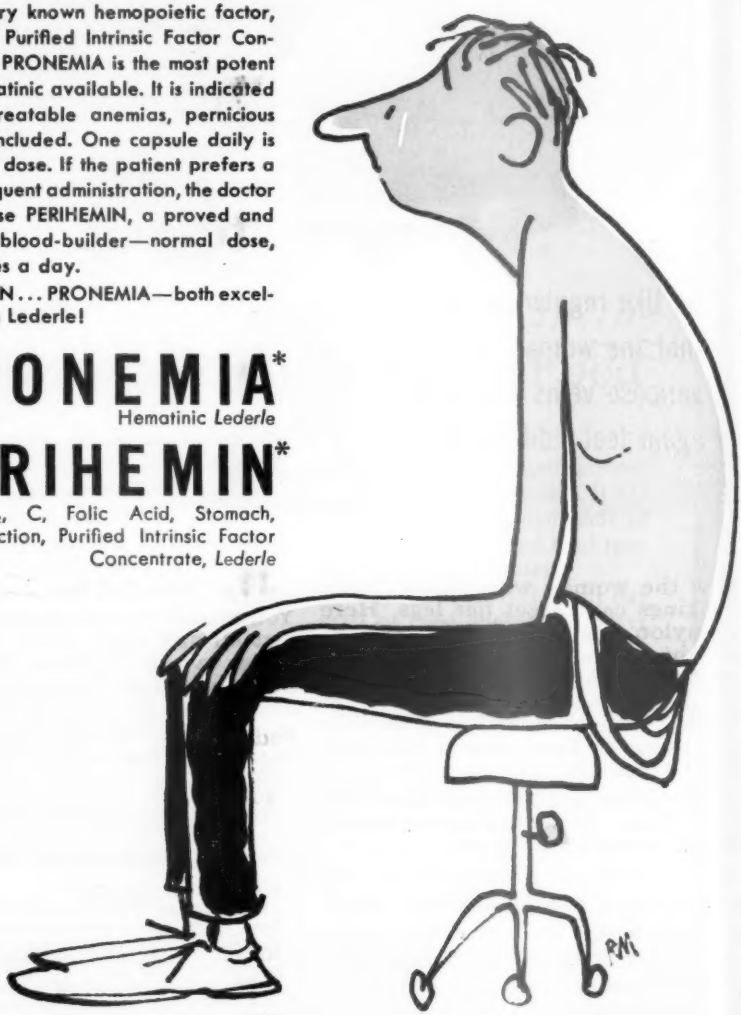

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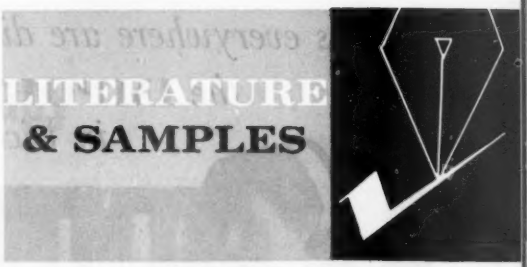

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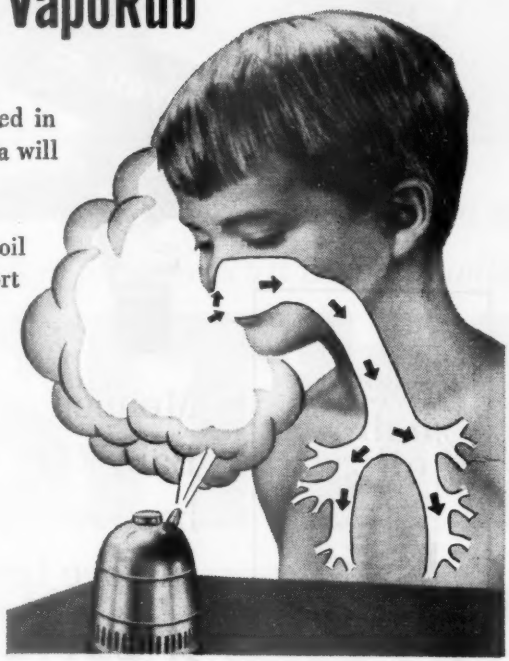

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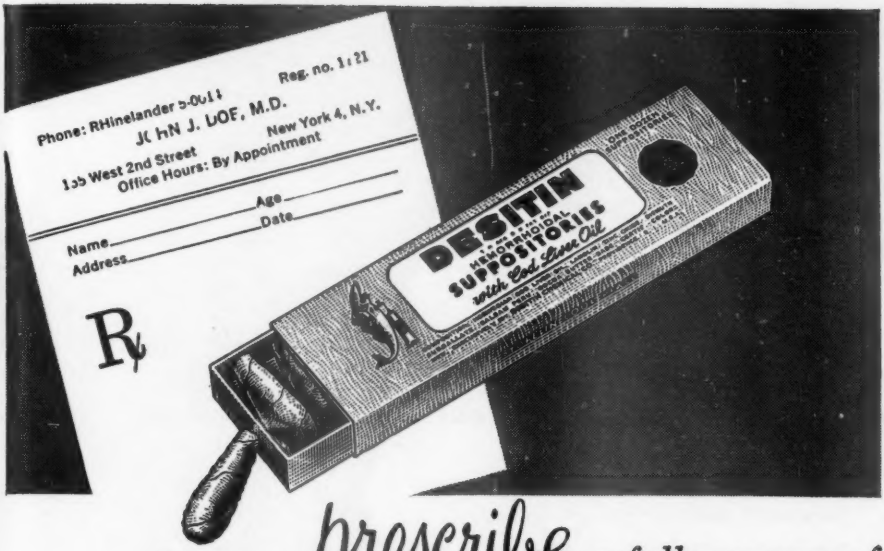

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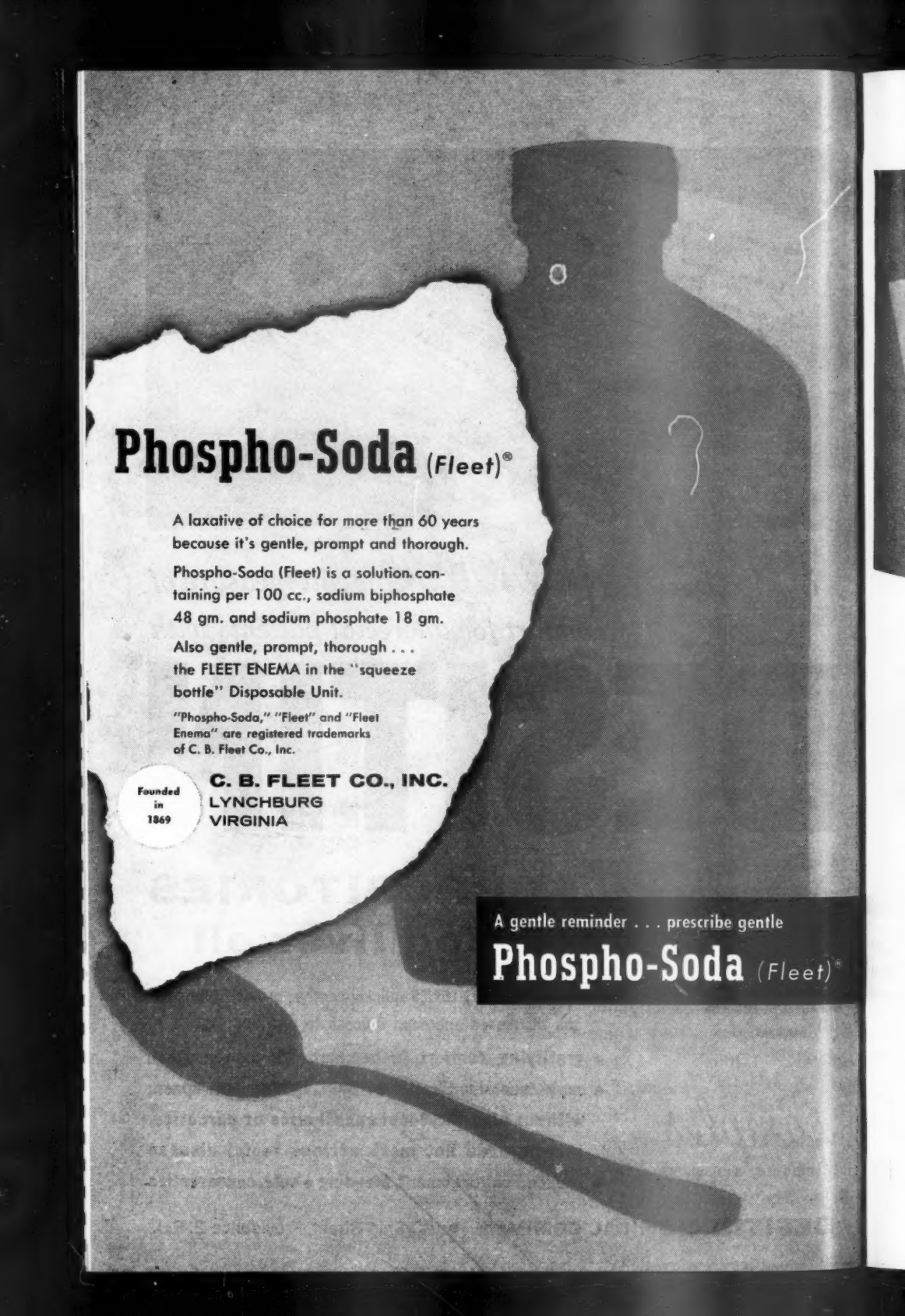
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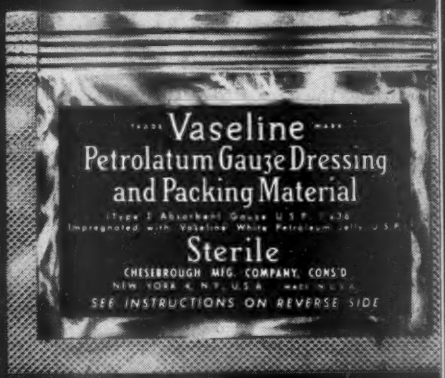

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References: 1. Gershenfeld, L., Am. Jl. Pharm.: 126:112, 1954.
2. Yarlett, M. A., Gershenfeld, L., McClenahan, W. S.: Drug Standards 27:205, 1954.

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Our hospitals' windfall

How to spend 200 million dollars? This is the least of the problems confronting some 3,500 voluntary non-profit hospitals of our nation, recipients of the Ford Foundation's magnificent philanthropical gesture. Every hospital trustee, administrator, department head, staff member, as well as every past, present, and future patient has his own ideas as to how to put this magnanimous gift to work.

Computed on the basis of patient-days of service provided by the hospital and the number of hospital births, the Ford Foundation's grant to individual hospitals ranges from $10,000 to $250,000. It is a single, non-recurring donation, and is limited in that it must be used "to improve and extend the hospitals' services to their respective communities," but cannot be used by the hospitals for current operating expenses. In other words, the Ford Foundation chose not to play the role of the wealthy relative who picks up today's tabs, but instead, chose to give to the future. Mortgages, salaries, and grocery bills must still be paid by collections from patients, insurance companies, and Community Chests' deficit financing.

Warnings, as well as limitations, are attached to the gift. The terms of the individual grants specify clearly that the full responsibility in spending these funds, in accordance with local needs and problems, is placed on the governing authorities of the recipient hospitals. All grants are made with the understanding that the Foundation will have no obligation for continuing to finance an improved or extended hospital service. After the initial grant is spent, other sources must be found for this purpose.

When such unprecedented philanthropy is seasoned with judicious caution, there should be no excuse for overextension on the part of

EDITORIAL

the grantees. Unfortunately, the lack of foresight in the use of Hill-Burton funds has left many hospital administrators open to criticism. The conception that a new building and/or additional wings will, in themselves, automatically guarantee a better quality of hospital service was found a bit less than valid when these federally aided hospitals tried unsuccessfully to staff their expanded facilities. The Ford Foundation has lifted the art of voluntary giving to a level heretofore unknown. Hospital trustees and administrators will need the wisdom and judgment of Solomon to respond in kind.

It takes more than a building program to make an accredited hospital. It takes qualified people. A hospital budget may be balanced by weighting the nursing staff on the subprofessional side, but this balance occurs only on the books. The quality of patient care is far from balanced. The Ford Foundation dramatically demonstrated the importance it attaches to securing and maintaining qualified people in the terms of its grant to the field of education. A grant of 210 million dollars to privately endowed colleges and universities was motivated by the Foundation's sincere belief that "Private and corporate philanthropy can make no better investment of its resources than in helping to strengthen American education at its base—the quality of teaching."

Whatever sum a hospital receives in Ford grants, its real worth to the community will eventually be measured by one yardstick—the quality of care its patients believe they are getting. For just as the core of the educational system is the quality of its teachers, so the core of the hospital is the quality and competence of its professional staff. Improved equipment and extended services are most certainly needed, but it is the doctors, not the patients, [*Continued on page 70*]

In her usual direct fashion, Florence Nightingale voiced the need for convalescent facilities almost a century ago. "It is a rule without exception," said Miss Nightingale, "that no patient ought ever to stay a day longer in a hospital than is absolutely necessary for medical or surgical treatment. What then is to be done with those who are not yet fit for work-a-day life? Every hospital should have its convalescent branch and every county its convalescent home."

Apparently this strong recommendation had little immediate effect in this country, for as late as 1930, there were only 179 institutions for convalescent patients, with a bed capacity below 9,000. Slowly, however, physicians are realizing that hospitalization periods can be shortened and readmissions reduced if good medical supervision is available after hospital discharge. And some communities are waking up to the economic fact that well-planned convalescent facilities may mean dollars-and-cents savings. According to one estimate, the per-patient-day cost of convalescent care represents an investment of about 50 per cent of the acute hospital patient-day cost.

Associated with this medico-economic awakening are new concepts of convalescence itself. Gone are the days when fresh air, good food, and a pleasant atmosphere were the most important ingredients of the patient's recovery period. Convalescent care must now be geared to the complex physical and psychological needs of young and old —mostly older—patients.

New medical and surgical advances have changed conditions now found among patients referred for convalescent care. No longer do we see patients with severe respiratory infections, mastoiditis, etc. On the other hand, techniques in cardiac surgery have resulted in more convalescent cardiac patients.

Just as convalescence has been called "the third phase of medicine," so it might also be a third phase of nursing. This phase requires a special alertness to detect untoward changes in the patient's condition, and experience and skill in evaluating complaints and findings. The latter is especially important in homes where there is no resident physician.

Kindness, consideration, and understanding are basic requisites in this field of nursing. But in addition, there must be some knowledge of rehabilitation— how to develop the patient's interest in becoming a self-sufficient person, "fit

for work-a-day life." There is a definite place here for the older, experienced nurse, but none for those looking for a simple, easy-chair job.

Nurses in convalescent homes have the opportunity of helping patients bridge the gap—sometimes wide—between invalidism and normal living. It is during this period that they assist patients in acquiring such habits as good posture, weight control, and proper dental hygiene. And in so doing, they have the satisfaction, sometimes denied their general duty colleagues, of *truly* nursing their patients back to health. Convalescent nursing also offers a virtually untapped source for research in physical and mental health.

Housing for convalescents ranges at present from ramshackle rest homes offering custodial care to luxury institutions providing the latest in rehabilitative services. Generally speaking, though, facilities fall into three classes: (1) non-profit units integrated or affiliated with general hospitals, located either on or away from the hospital grounds; (2) non-profit, independent homes fortunate enough to be financed by sources such as endowments; and (3) homes operated independently for profit.

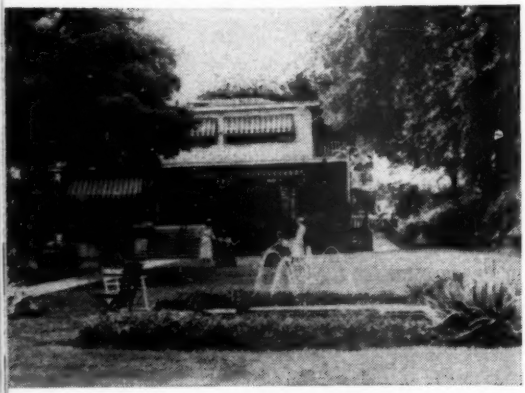
In the first class are facilities which follow the 1947 recommendation of the Hospital Council of Greater New York that convalescent units constitute an integral part of the general hospital. The recommendation stemmed from the

ST. LUKE'S CONVALESCENT HOSPITAL

MARY HARKNESS CONVALESCENT HOME

STORROW HOUSE

BURKE CONVALESCENT HOME



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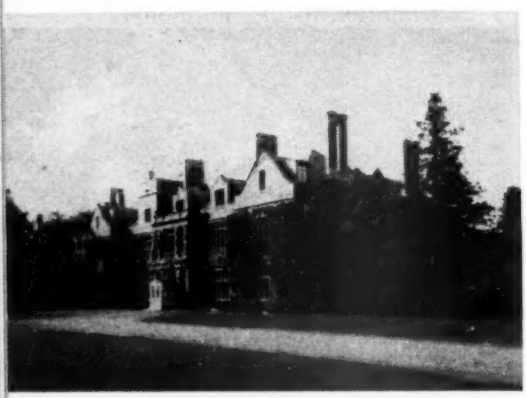


KATE MACY LADD CONVALESCENT HOME

fact that medical care is needed for most of the 70 per cent of general hospital patients requiring convalescent services after recovery from acute illness or injury. The Council also noted that close association of such units with a general hospital would encourage investigation in the field of convalescence as well as ensure the necessary continuity of medical care.

An excellent example of a general hospital convalescent unit is St. Luke's Convalescent Hospital in Greenwich, Conn., a branch of St. Luke's Hospital, a voluntary, nonprofit institution in New York City. Since its establishment in 1927—when convalescent care was primarily of a rest-home type—this unit has gradually expanded to include such services as physical therapy, occupational therapy, and planned recreation.

Some 30 miles from the parent hospital, St. Luke's is located in Byram Woods, a vast acreage of woodland, flower gardens, lawns, and ponds. The place was a gift of Mrs. Hicks Arnold who also provided for the erection of a convalescent hospital. Today the institution consists of two fireproof buildings with beds for 50 adults and 45 children. There is also a 20-bed ward for full bed care of children with such conditions as rheumatic fever, chorea, and orthopedic disabilities.

Admission policies are liberal, for the Greenwich unit is equipped to care for almost all types of patients except mental cases or adults

requiring bed care. It should be noted, too, that no distinctions are made as to age, sex, race, or creed. It's an inescapable fact that often such distinctions are awkwardly or frankly admitted by other convalescent institutions, especially those operated on a private, independent basis.

Among other country convalescent branches maintained by voluntary, non-profit hospitals are the Mary Harkness Convalescent Home in Port Chester, N.Y., and the Neustadter Home in Yonkers, N.Y. It's interesting to note that the development of both these units was also made possible through philanthropic sources. The 80-acre site of the Mary Harkness Home was willed to the Presbyterian Hospital, New York City, and its brick colonial two-story structure was built from funds donated by Mary Stillman Harkness. The Neustadter Home, a model convalescent unit affiliated with Mount Sinai Hospital in New York City, was completely renovated in 1949 as a result of generous gifts.

Apparently hospital gratitude toward gifts of buildings may be somewhat tempered by experience. There is a question, in some cases, of whether gifts of large, country mansions to general hospitals justify their use as convalescent units. The remodeling needed to accommodate patients, the upkeep of spacious lawns, and the difficulty of attracting nurses and other personnel to relatively remote areas are all factors that could create financial headaches. Some voluntary hospitals, however, like Massachusetts General Hospital in Boston, Mass., have substantial endowments earmarked for convalescent purposes. The endowment income for MGH's convalescent branch, Storrow House, in Lincoln, Mass., is sufficient to meet the difference between operating costs and payments made by patients.

Perhaps one solution to the problem of combining country living with the advantages of close proximity to the parent hospital is the plan of the Jenks Convalescent Unit of Huntington Memorial Hospital in Pasadena, Calif. This cottage-like building in a garden setting is removed from the main hospital for privacy but connected with its services by means of a covered passageway. Large twin-bed rooms open onto private patios, and at the end of each wing is a paved, covered terrace for the patients' use on sunny days.

In these pleasant convalescent surroundings in California, most of the nursing care is given by aides and vocational nurses (practical nurses) under the supervision of a professional nurse. Nursing is geared to helping the patient achieve full recovery, and custodial care is definitely not a nursing function.

An outstanding example of a convalescent home providing continuity of medical care under auspices other than those of the general hospital is the Burke Convalescent Home in White Plains, N.Y.,

endowed by a non-profit organization. The buildings, arranged on the cottage plan on a landscaped, 60-acre plot, house about 150 guests. All cottages are connected by covered walks and by underground passages. There is a private pavilion for those desiring more secluded living quarters or for those requiring more intensive medical or nursing care.

This modern home offers a convalescent service geared to the modern concepts of chronic disease, geriatrics, and psychosomatic medicine, and a rehabilitation service for the treatment of patients with residual disabilities from neurological, musculo-skeletal, and cardiovascular disease. It also operates an outpatient clinic for children with cerebral palsy.

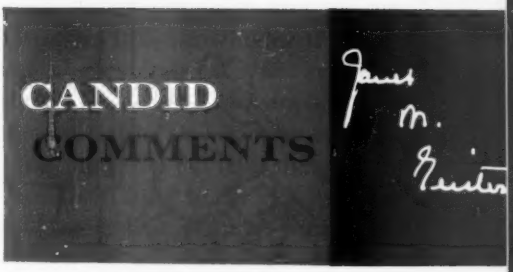
Patients admitted to Burke include those recovering from illness or disability—but whose doctors report that they cannot yet be cared for in their own homes. Applications are made by patients' physicians; and to ensure continuity of medical care, the home requires complete medical data on application forms. Up until the last war, convalescent care was provided free of charge, but now patients are billed according to their ability to pay.

What might be classified as an on-going experiment in preventive psychiatry is the McGregor Center in Detroit, Mich., under the direction of the McGregor Health Foundation, a non-profit corporation. About fifteen minutes from downtown Detroit, the Center, which accommodates 35 patients, is located on property extending to the Detroit River and adjoining a park. Opened in 1940 "to provide medical conditions, including favorable surroundings, for the recovery of health," the Center rejects the term convalescent home, preferring to call itself a hospital for rehabilitation and health education.

The McGregor organization considers the Center a laboratory for research work, for it is not run for profit, nor is it self-maintaining. Nevertheless, a good part of the maintenance expense is covered by patients' payments.

It is difficult to pinpoint the spirit of this institution, but from patients' and doctors' accounts, its care appears to be of high order. A typical patient's comment is this: "I have never received such good and interested care anywhere before. When a nurse comes into your room, uncalled, to ask if there is something she can do for you, it is most unusual these days." The leadership in this unique institution comes from its medical director, Dr. John M. Dorsey, who is also professor and chairman of the Department of Psychiatry of Wayne University.

Another in the category of homes financed by non-profit foundations for the sole purpose of providing convalescent care is the Kate Macy Ladd Convalescent Home in Far Hills, N.J. An unusual feature of this home—unusual in these days of high [*Continued on page 76*]



Getting set to live

"What openings do you have on your administrative staff," inquires a 22-year-old of a nursing administrator; "I will get my degree soon and will be ready to go into administration." From another expectant graduate comes a letter, "I'm being married right after graduation. We'll be buying a house with a 20-year mortgage, so I'll shop around for the best-paying job I can find." A third tells me, "There's no percentage in this business of higher education. I could manage more schooling—Dad is willing. But I can get all the work I want without bothering."

These examples of some rather common attitudes are the product of the times. We live in a period of vast change that focuses thoughts on the present; tomorrow is vague and uncertain. We lower our sights to what we can wrest from today. Yet if ever there was a time when young people needed to look forward it is now, for there is a long span of years ahead of them.

Today's young people are going to live more years *after* their families are grown up and married than they did before the children came. They are going to compete in a world that is steadily demanding better preparation and greater skills of its workers. They are building the kind of characters they will have decades hence, when losses in physical powers will need to be offset by the more enduring spiritual and mental powers. It is in youth that the pattern is set which largely determines if the later years are to be tragic endurance tests or periods of fulfillment.

Whether or not a nurse retires permanently from professional work when she marries, the fashions of life are vastly different from those of Grandma's time. The whole pattern has changed, not only in its ice-boxes and washing machines, but in its vistas. The main part of our grandmother's life was over by the time her children had moved on to their own careers. Our grandmothers didn't have to find ways to occupy themselves after the rearing job was done, and there was always room for them in the big houses. Today, there are a lot of "lost" grandmothers without a place in life. A surprising number have gone out to work in factories and shops, some because they need money, others because they need to be busy at something useful. With life expectancy stretching to the point where thoughtful people predict 100-year spans, there is still a "heap of livin' " to be done after the first half-century.

Youth is the time for laying foundations, and the young grad-

uate of a recognized nursing school has a solid foundation on which to build. But it isn't of much value as a base if upon it is erected something that falls apart in a few years, or just "gets by." There is nothing wrong with a young nurse who wants to go into administrative work; quite the contrary. But she builds on sand rather than rock if, in directing the work of others, she fails to appreciate the value of seasoned experience. Nor is there anything wrong with a nurse who pitches in to help pay for a home. But taking a job on the basis of salary alone may mean getting into a lifelong rut.

It *is* wrong, though, to set one's educational goals on the basis of the present plenitude of jobs. No one can keep pace with today's swift march without an attitude and an avenue for continued learning—and this learning *can* be a delight and profit, not a chore. "Don't make the *degree*, but *learning*, your goal," I wrote an inquiring nurse. "Get as much education as you can. A degree is important and valuable, but it doesn't automatically mean that you are educated. Education comes of a hunger for learning. It is a lifelong process that not only increases your usefulness but puts things into your life that no circumstance can take away."

Today we can measure our lives with considerably more certainty than was possible yesterday. The present generation could not anti-

cipate the extra years that the health revolution is giving them. Their attitudes toward life's tenure were established on Nineteenth Century conditions, just as were those of the nameless authorities who set 65 as the age for the rocking chair.

Nor did society understand and prepare for the social, psychological, and economic situations that a growing army of older people would bring. The result is a mounting mass of loneliness, fears, and dependency. There can be no greater misery than to feel oneself a burden, to feel unneeded, and to eke out one's days on scant rations of physical, spiritual, and mental comforts. It is no wonder that our mental hospitals are so crowded with bewildered old people. Conversely, there can be no more satisfying periods of life than older years lived fully to the last.

"People fear old age because of what society does to old people," says Ben Grossman, authority on the problems of the aging. The tide is beginning to turn, and many movements are afoot to redeem and enrich these "extra" years. For the present, much of this action is ameliorative; we can't turn back the clock. It is the young who can get in the preventive work. The number of aging members is as

large proportionately in nursing as in any other group, and it's high time for organized nursing to recognize this problem.

The whole stress on preparation for old age has been on saving money—"a roof over my head." But even when this is possible, it is not enough. The latter years must have purposes and satisfactions of their own—when one can live a life of dignity and self-respect. Life is God's supreme gift; it is meant to be reverenced by ourselves as well as by others. Advanced years call for a change of pace, perhaps a change of occupation, but they do not demand that mind and spirit take to the rocking chair. Fruit that ripens on the tree is fruit at its best. I once spent a day at a "poor farm." Though the county's indigent were cared for with kindness and generosity, I was struck by the stillness of these people, by their resigned attitudes of waiting, simply waiting. Waiting for what? For death—the only door still open to them.

Not long ago I had another moving experience in facing a large audience of "senior citizens," most of them over 75. In the faces looking up at us were etched the individual records of seven and more decades of living. "A man's look is the work of years, it is stamped on his countenance by the events of his whole life," wrote essayist William Hazlitt. Here we had a panoramic view of what humans make of life, and life makes of humans.

What made the difference between the dull resignation we saw in some faces and the deep serenity we saw in others? Heredity, environment, social and economic forces were undoubtedly all major factors. But certainly personal attitudes and habits of thought were equally potent, if not more so. I was taught that the best way to save money is to build up an account with something from every pay check. That is the way we build up our lives, day by day, in the multitude of little and big acts and thoughts that crystallize our characters. At any age we are the sum total of all the days that have gone before, of our thoughts, ideals, plans, and actions. Our attitudes and ideas count powerfully in the way we meet life's exigencies, responsibilities, and opportunities. It behooves us, then, to take heed of the ingredients we put into living. We are doing more than earning money; we are building a person.

No one can draw up a blueprint of the events of living for the decades ahead. When I look at the checkerboard of my own experiences I am very glad that this is so. All the zest would have been taken away, and I'd have missed some grand adventures in the health march. The important thing is not the unpredictable events, but rather our ability to meet them. It is the quality of the people who handle the events, not the events themselves that determines the course of nations, professions, individuals.

The present generation had no reason to [*Continued on page 69*]

IDEA OF THE MONTH

A design for the future

A plan to promote dignity and economic security for bedside nurses.

by Florence L. McQuillan

ANYONE who has delved into medical history remembers that melancholy era back in the Middle Ages when barbers and midwives assumed the work which physicians considered beneath their professional dignity. Thinking they could advance the healing art by academic study alone, doctors had gradually divorced themselves from actual patient care, leaving what they called the "menial tasks" to others. Eventually, however, when it was found that medicine had thus entered a dead-end street, leaders of the profession returned to the world of reality; and long before our day, practice in the ward, the clinic, and the amphitheater came to be recognized as the foundation stone of professional progress.

Are modern concepts of nursing now leading us down another dead-end street? Let's look at the record:

For years we nurses have been struggling to maintain our professional status. Yet instead of building on that firm foundation which is our birthright—namely, *bedside nursing*—we have been led to believe that we can advance professionally by delegating patient care to others while we, ourselves, become armchair strategists, basking in the glory of officious-sounding titles and academic degrees.

Why isn't it plain to all of us that nursing can progress only by the recognition of its own worth at the bedside?

Without doubt, we are suffering from an acute case of lowered morale. Talk and platitudes will not remedy this condition. The nurse needs concrete evidence that the dignity of bedside care is the truly acknowledged backbone of the profession; and this concrete evidence must come, mainly, in the form of better pay.

We all know that there's nothing like a salary raise to lift one's morale. And in most cases, it isn't the added income that does the trick; it's the recognition of one's worth as an individual.

Thus, any program aimed at raising the dignity of nursing should begin by considering the nurse's

economic incentives. How can she maintain her self-respect if she fares no better financially than the unskilled, untrained worker? What doctor would long be satisfied to work on a rigid salary basis which didn't take into account his individual skill and the number of patients he serves?

I realize, of course, that nursing is a work of service and dedication. Nevertheless, it isn't easy to maintain one's enthusiasm and good disposition in the face of financial straits. Moreover, most nurses have no long-range pension benefits to fall back on in their twilight years.

Aside from the salary issue, the staff nurse's morale has suffered by the brain-washing she has long undergone. Continuously she is told that "R.N.'s are doing nothing that couldn't be done as well by a practical nurse or an aide"; that "professional nursing has outgrown its bedside usefulness"; that "R.N.'s should teach and lead, but not nurse the sick." We have all heard such nonsense expressed.

Meanwhile, the underpaid staff nurse has various good reasons to be envious of her colleague on private duty: (1) The latter, with but one patient to attend, usually earns as much or more than the floor nurse with eight or ten to care for. (2) While her one patient convalesces, the private duty nurse can read, knit, or otherwise relax—an obvious impossibility on floor duty. (3) Private duty often affords time off at the nurse's own discretion. (4) As a rule, it also affords a much higher degree of professional satisfaction—by allowing the nurse to act on her own initiative and assume responsibility without undue interference.

Is it any wonder that conflicts frequently arise between the two fields? Is it any wonder that the staff nurse's morale is low and her professional ego frustrated? Is it any wonder that she seeks escape in private duty—the only branch of nursing which permits her to stand on her own two professional feet?

Yet comparisons between these two fields get us nowhere—and dissension between them is akin to race suicide. We need to think of ourselves as a unified profession—and act accordingly.

The question is: What can we do, as a unified group, to give bedside nursing the professional dignity it merits and the economic incentive it needs?

I have given considerable thought to a plan which, I am convinced, could be worked out successfully with the support of hospital administrators and the public. Its development will obviously require the considered opinions of others: hence, I shall not endeavor to go into all its fine details but merely to present it in outlined form as an idea for discussion and, if need be, modification.

I propose that the hospital staff nurse be paid a daily professional fee by each patient she attends. Nursing, it seems to me, has too long been included as a "package

offering" of the hospital along with room, board, and maid service. Actually it is a professional service, rendered by an individual to an individual; basically, therefore, it merits a professional fee to be paid directly to the attending nurse by the individual patient.

Five dollars a day doesn't seem an unreasonable amount to ask for the service the nurse must provide: she must bathe the patient, make him comfortable, and administer treatment and medications: she must answer his summonses for an eight-hour period; she must exercise her professional skill and vigilance, and report any significant changes in his condition.

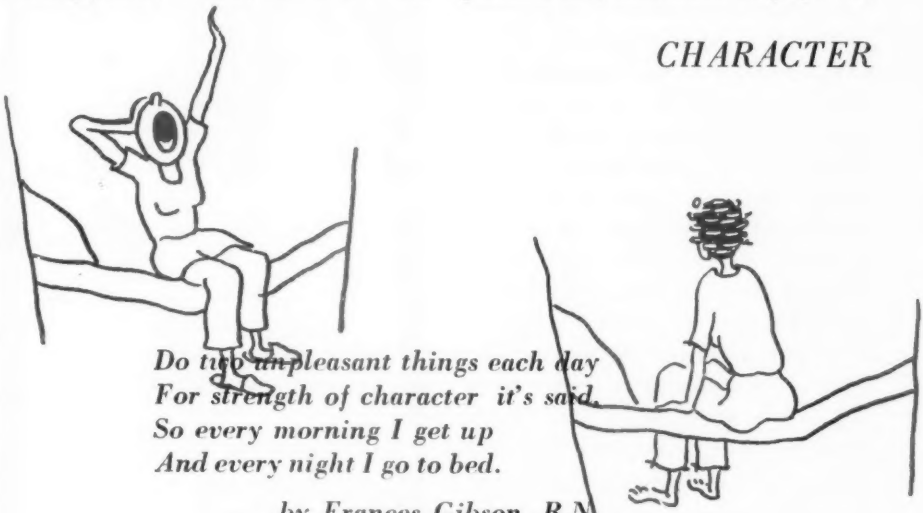
Other forms of service command a much higher rate. For example, people think nothing of paying a mechanic five dollars to make some small adjustment on a furnace, a refrigerator, a car, or a TV set which may take but a few minutes.

If the plan I propose were adopted, staff nurses would, of course, be removed from the hospital payroll; and since today's nursing costs are said to constitute between 40 and 60 per cent of a hospital's running expenses, its present daily rates could doubtlessly be reduced.

I realize, naturally, that the proposed plan involves many other factors—such as hospital and Blue Cross economics, legal responsibility of the hospital, administrative policies, and the supervision of nursing care. Yet I feel that the advantages inherent in the plan justify its consideration in spite of the obstacles it would face. These advantages are:

(1) Nurses would have a sound economic incentive to remain in (or return to) general duty. (The more patients an [*Continued on page* 78]

CHARACTER



Do two unpleasant things each day
For strength of character it's said.
So every morning I get up
And every night I go to bed.

by Frances Gibson, R.N.

NURSES through

Barco's historical mannikins came to life at the Utah State Nurses Association convention last fall in a fashion show called "Nurses through the Centuries." Arranged by Robinson's Medical Mart, the exhibit featured nurses' uniforms dating back more than 700 years. Barco of California provided the historical uniforms which were modeled by students. Intrigued by the performance, *R.N.* requested a special showing for our readers.

YEAR OF 1242

Members of the Catholic Order of Canonesses of St. Augustine have been reported to be among the first women in history to organize and direct nursing of the sick as a permanent vocation. The present-day Missionary Canonesses of St. Augustine are well-known and honored throughout the world for their helpful and benevolent work among the sick and underprivileged and for the leper colonies which they operate in the Philippines and India. Carrying on age-old traditions, but following the latest health teachings, these dedicated women wear almost the same style of habit as that worn by the original founders.

the Centuries

YEAR OF 1540

This is one of a group of women who first dressed alike in performing nursing duties. At the court of Henry VIII, there were six women wearing this uniform. These handmaidens, as they were called, cared for the sick and wounded and served as midwives. Our present nomenclature is derived from this period when wet nurses used to nurse royal children. The word "nurse" was soon applied to those attending the sick outside of the nursery; and eventually handmaidens were called nurses.

MODEL: Farrel Andersen of Thomas D. Dee Memorial Hospital

YEAR OF 1775

This nurse made her first appearance at the Battle of Bunker Hill when General Israel Putnam enlisted the aid of the ladies of the church to care for the wounded, thus releasing needed manpower to defend the town of Boston. She is further symbolized in the person of "Molly Pitcher" who took over the firing of a cannon when her husband, a cannoneer, was killed at the Battle of Monmouth. General Washington commissioned "Molly Pitcher" as the first woman lieutenant in the Continental Army.

MODEL: Jo Ann Matich of St. Benedict's Hospital

YEAR OF 1863

This particular nurse was on duty at the Battle of Gettysburg. Although she was with the Confederate Army, she proved to be a true Angel of Mercy by impartially attending thousands of sick and wounded soldiers of both armies in this battle which was one of the most violent in American history. A few years earlier, on the other side of the world, Florence Nightingale was establishing her place in history, and laying the foundation for modern military nursing, by her activities in the Crimean War.

MODEL: Helen Bower of Latter-Day Saints Hospital

YEAR OF 1880

The nurse in this uniform set the pattern for the education of our present R.N.'s. The Seventies and the Eighties saw the founding of such famous schools as Bellevue, Massachusetts General, Brooklyn, and Johns Hopkins. These four and others established during this period were based on the renowned Nightingale School at St. Thomas' Hospital in London, established in 1860 by Florence Nightingale. The bold stripes may be seen in many student uniforms today but the tuxedo tie has disappeared.

MODEL: Nancy Friel of Holy Cross Hospital

YEAR OF 1900

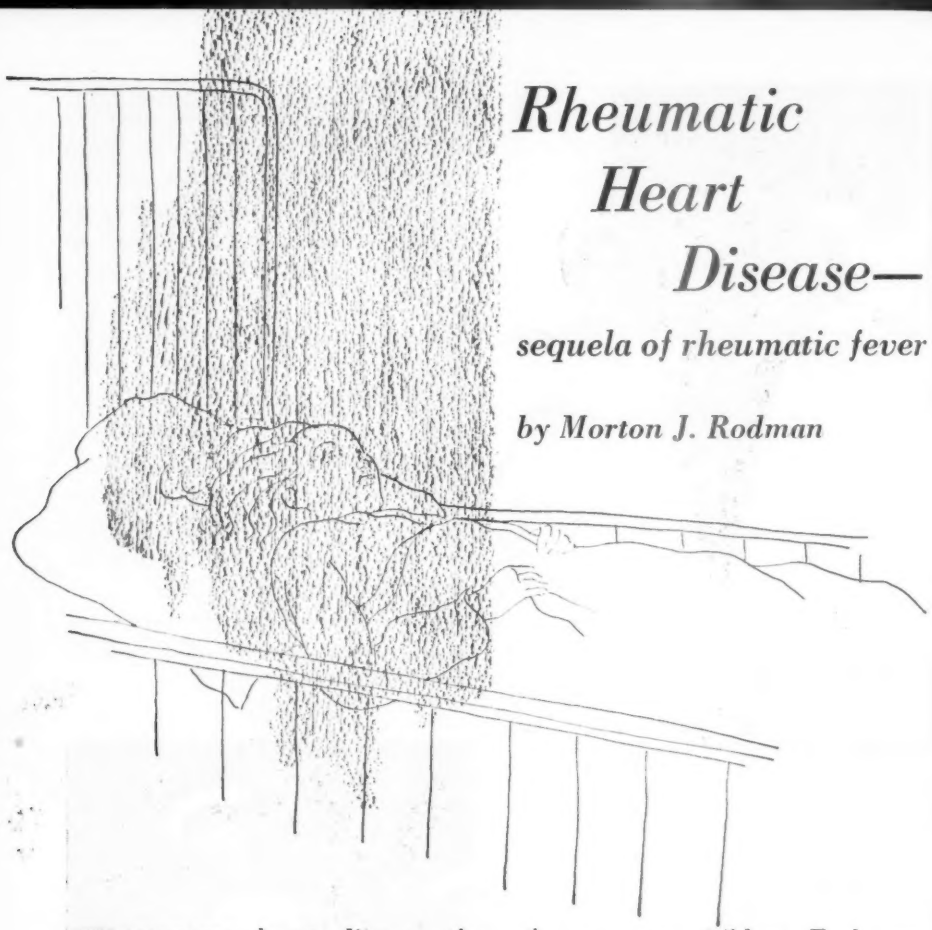
Embodying the spirit of Clara Barton, skillful amateur nurse and founder of the American Red Cross in 1881, this nurse was serving on the first American Red Cross ship, the "State of Texas," during the Spanish-American War of 1898. She was one of a group of five graduates, the only nurses in the Cuban phase of the war who actually administered to combat casualties. So indispensable was the nursing service to the armed forces during this war that it paved the way for the Army Nurse Corps in 1901.

MODEL: Marilyn Moyes of Salt Lake County General Hospital

YEAR OF 1925

Here is a representative of the never-to-be-forgotten Jazz Age. It would be unfair to say that all nurses of this era wore uniforms this exaggerated. Admittedly, this is an extreme example. It's important to note, though, that the fashions of the day influenced nurses in their selection of uniforms. Despite her abbreviated attire, this model might be one of the forerunners of today's more discriminating nurses who demand the same smart styling in uniforms as they do in street clothes.

MODEL: Karen Heaton



Rheumatic Heart Disease—

sequela of rheumatic fever

by Morton J. Rodman

RHEUMATIC heart disease, the devastating cardiac condition that so often follows rheumatic fever, is one of the commonest causes of death and disability in the United States. According to Public Health Service statistics, cardiac complications of rheumatic fever caused 21,000 deaths in 1953. Some medical men set the figure much higher, because many deaths in the middle years of life, listed as due to arteriosclerotic heart disease, are actually the late result of childhood rheumatic fever.

The most tragic aspect of this form of heart disease is its prevalence among children. Each year rheumatic fever cripples more youngsters between 5 and 19 years of age than any other illness; rheumatic heart disease kills five times as many as polio, whooping cough, meningitis, and measles combined.

Despite these grim statistics, considerable progress has been made recently in the prevention and treatment of rheumatic fever and its sequelae, and studies are being made of the basic mechanisms of the rheumatic processes that result in damage to connective tissues of joints and heart.

While the exact cause of rheu-

matic fever is still unknown, the disease almost always follows an invasion of the upper respiratory tract by Group A hemolytic streptococci, the organisms that cause streptococcal sore throat. Yet rheumatic fever results from only a small percentage of such streptococcal infections.

Some investigations have suggested that the disease may be an allergic reaction to foreign proteins produced by the invading bacteria. These may act as antigens that cause the tissues of hypersensitive individuals to react with an excessive production of antibodies. In some manner still not understood, the antigen-antibody reaction then results in the typical tissue inflammation of rheumatic fever. Evidence in support of this theory includes the comparatively high titer of antibodies, such as antistreptolysin-O, in rheumatic fever sufferers. Other scientists think that the destructive changes that occur in the connective tissues are caused by non-antigenic chemicals released by the streptococcus.

While there is no real cure for rheumatic fever, proper treatment begun early and carried on carefully for many months may do much to prevent heart damage. Anti-rheumatic drugs in adequate dosage may suppress the inflammatory process in the heart and lessen the formation of the fibrous tissue that can scar and deform the heart valves.

Salicylates, such as aspirin, have been shown to be effective, not only for the relief of pain, but also to reduce inflammation of the joints, the endocardium, and pericardium. Massive doses of salicylates administered during the acute inflammatory exudative stage may prevent congestive heart failure. Yet some young patients do die during an acute attack despite such treatment.

The place of hormones in the treatment of rheumatic carditis has been somewhat controversial. Certain widely publicized studies have indicated that adrenocorticotropin (ACTH) and cortisone were no more effective than aspirin in reducing rheumatic carditis. However, the results of more recent work, in which treatment was begun early with much larger doses of the hormones and continued for several months, suggest that the adrenocorticoid steroids may be the drugs of choice for early treatment. The newly developed synthetic hormones, prednisone and prednisolone (see R.N., Dec. 1955), may prove especially effective, as

they produce equally good or even greater suppression of inflammation with less risk of undesirable side effects, such as edema due to salt and water retention.

Though neither salicylates nor hormones are capable of completely breaking the chain of biochemical reactions that presumably occur between the initial strep infection and the onset of rheumatic fever, evidence is accumulating that the drugs may control some of the factors thought responsible for triggering the inflammatory process. The steroid hormones, for example, markedly reduce the concentration of streptococcal antibodies in the blood and tissues. This should, of course, lead to a reduced antigen-antibody reaction and consequent prevention of inflammation, if the "allergy" theory of rheumatic fever pathogenesis is correct.

Researchers have recently reported the ability of cortisone, prednisone, and corticotropin to prevent completely the development of the typical subcutaneous nodules that are seen at various extra-cardiac sites after attacks of rheumatic fever. Since these nodules are histologically similar to Aschoff bodies, the characteristic fibrous scar tissue found in the hearts of rheumatic fever victims, the investigators infer that the hormones may, in much the same way, inhibit the formation of cardiac lesions.

This scar tissue that forms in the heart after repeated attacks may often deform the valves, including the mitral valve between the left auricle and left ventricle. The gradual narrowing of this opening may obstruct normal blood flow, and failure of the valve to close completely when the ventricle contracts can cause some of the blood to be regurgitated into the auricle instead of being pumped out into the aorta. As a result, the heart has to work harder to maintain its normal flow of blood.

At first, enlargement of the heart muscle may compensate for the valvular defect. Eventually, however, especially after recurrent rheumatic infections, the overworked heart may begin to fail. Then fluid begins to back up into the lungs, making breathing painful and difficult: other viscera also become engorged with edema fluid. and death may result from circulatory failure or other complications which involve the lungs, liver, and kidneys.

Patients with these classic signs of mitral stenosis and congestive failure are now considered candidates for commissurotomy, a life-saving surgical operation for correcting cardiac valve deformities. In this operation, the surgeon makes an incision in the left auricle, locates the damaged valve by touch, and widens the opening either with his finger or a tiny knife that fits over the finger. It is hoped that the advances in anesthesia that have made such surgery possible will be followed soon by further improvements enabling the

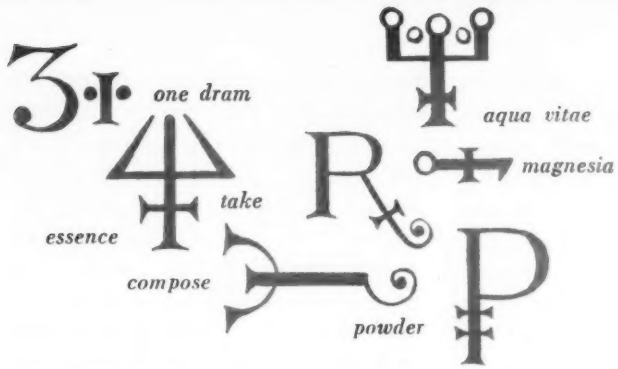
surgeon to work on a quiet, dry field, instead of blindly on the blood-filled, beating heart.

One way in which this ideal has been approached in a few experimental cases is by the use of "artificial hibernation": the patient's body temperature is lowered to below 80° F. by means of ice packs and ice water-alcohol mixtures. This results in a reduction of cellular metabolism that allows the tissues to get along with minimal amounts of oxygen for quite some time. When the body's chemical processes are slowed to the point where they may be maintained for several minutes by the oxygen already available in the circulating blood, the chest is opened and the blood vessels to and from the heart are clamped off. The surgeon can then repair the defective valves (or other cardiac damage) under direct vision and without fear that lack of oxygen will damage the brain or other vital tissues.

Another advance that may widen the scope of cardiac surgery is the development of an artificial heart-lung apparatus which substitutes for the [*Continued on page* 72]

PROBIE

"I'LL RACE YOU TO THE SUN-DECK."



CORTICOTROPIN INJECTION U.S.P (*Anterior Pituitary Hormone*)

PROPRIETARY NAME: Acthar

PHARMACOLOGY: The adrenocorticotropic hormone (ACTH) exerts its effects by stimulating the adrenal cortex to secrete its spectrum of steroid hormones. Thus the metabolic and physiological effects of corticotropin are due to the adrenal corticosteroids produced in this manner, and the hormone is useful in almost all of the various conditions for which cortisone, hydrocortisone, and prednisone are indicated. These include acute rheumatic fever, rheumatoid arthritis, and other inflammatory conditions involving the collagenous tissues, skin, and eyes, as well as stressful emergencies.

DOSAGE: Intramuscular injections of 40 to 50 U.S.P. units may be given in four divided doses daily and increased cautiously up to 100 units daily.

UNTOWARD ACTIONS: Various undesirable hormonal and metabolic effects may occur with the use of corticotropin for long periods, including sodium retention, rise in blood pressure, and hirsutism. Allergic reactions may also occur.

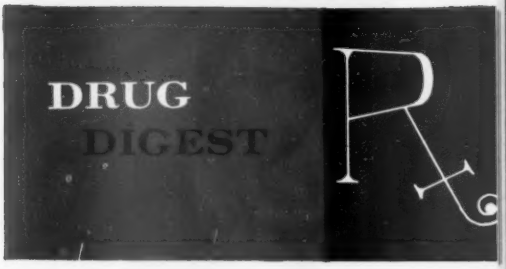
HYDRABAMINE PENICILLIN G N.N.R. (*Antibiotic*)

PROPRIETARY NAME: Compocillin

PHARMACOLOGY: Hydrabamine Penicillin G is a mixture of water-insoluble dipenicillin salts of a rosin amine base. It is used in the prevention and treatment of infections caused by penicillin-susceptible bacteria, including streptococci, staphylococci, pneumococci, and gonococci. Given by mouth, it is absorbed rather rapidly, even when administered with meals, promptly reaching adequate blood levels that are maintained for some time.

DOSAGE: For continuous prophylaxis in rheumatic fever, 300,000 units are given once or twice a day; if fever or other rheumatic symptoms occur in patients with a history of rheumatic fever or carditis, a ten-day course of treatment should be instituted with daily doses of 800,000 to 1,200,000 units for the first five days and about 700,000 units daily for the last five days. In other infections, 300,000 to 600,000 units four times a day may be given.

UNTOWARD ACTIONS: Allergic reactions are possible, as are monilial infestations of the gastrointestinal tract.



HYDROCORTISONE U.S.P. (*Adrenal Steroid Hormone*)

PROPRIETARY NAMES: Cortef; Cortril; Hydrocortone

PHARMACOLOGY: Hydrocortisone is a natural adrenal steroid somewhat more potent than cortisone in its anti-inflammatory and stress-combatting actions. Like the latter, it can reduce the fever, arthralgia, and general toxicity of acute rheumatic fever and lessen the local swelling, tenderness, and redness of rheumatoid arthritis. Other collagen diseases such as acute disseminated lupus erythematosus are also temporarily improved, but symptoms tend to reappear shortly after therapy is discontinued. Hydrocortisone may be lifesaving against the acute respiratory embarrassment of status asthmaticus, laryngeal edema, and allergic emergencies.

DOSAGE: Dosage, determined by the patient's condition and his individual response, should be adjusted to the minimum amount for relief.

UNTOWARD ACTIONS: Careful control of dosage, by means of laboratory and metabolic studies is advisable because of the many hormonal and metabolic imbalances that can occur, including sodium retention.

PHENOXYMETHYL PENICILLIN (*Antibiotic*)

PROPRIETARY NAMES: Pen•Vee•Oral; V-cillin

PHARMACOLOGY: Phenoxymethyl penicillin or penicillin V is a new antibiotic produced by biosynthesis and isolated as a white, crystalline powder. Penicillin V is not destroyed, as are most other forms of penicillin, by the acids of the stomach. Dissolving in the alkaline intestinal fluids, it is absorbed rapidly from the duodenum and produces blood levels that are said to be higher than those produced by other oral penicillins.

DOSAGE: In rheumatic fever, to prevent recurrent attacks, 200,000-500,000 units are given daily; as prophylaxis against secondary infections in patients with a history of heart disease, 200,000-500,000 units may be given every four or eight hours before, and for several days after, tooth extractions, tonsillectomy, and other operations. In the treatment of infections by susceptible organisms, 200,000-500,000 units are given three to four times daily.

UNTOWARD ACTIONS: Allergic reactions may occur in individuals previously sensitized by other forms of penicillin.

THE PATENTS of PAULINE

by Al Graham

Photo: Ralph Pyle, Jr.

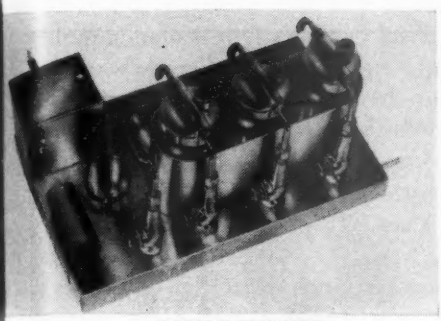
PAULINE BUECHEL, R.N., is a name to remember. You may never see it in Broadway lights, in Hollywood dispatches, or among the featured personalities in the popular magazines; yet, its owner may some day be ranked as one of the exceptional women in her field.

Inventor, nurse instructor, and key figure in the Buechel Products Company of Terre Haute, Ind., this modest R.N. has that happy combination of brains, dexterity, and charm which invariably presages success. As a matter of fact, her success to date in turning ideas into realities stamps her as a rarity among nurses and a genuine credit to her profession. That she will achieve still more in the future seems certain.

Even as a tiny tot, Kansas-born Pauline loved to tinker with things mechanical. "I can't remember a time when I didn't like to work with my hands," says the inventor of the Beuchel Hypodermic Needle Cleaner and various other hospital devices. "As a child, I delighted in taking toys apart and putting them together again. Often I improvised my own playthings, using spools, string, buttons, rubber bands, and so on. Later—in the third grade—I came home with a prize for building a wren house; and in high school, I took every available course in manual arts."

After completing her student-nurse years at Wesley Hospital, Wichita, (where, she says, "I had little opportunity except to follow the set patterns"), the young R.N. accepted a job in the hospital nursery and, in her spare time, began dabbling in applied mechanics. In due course came her first contribution to the betterment of hospital equipment: Finding the funnel method of oxygen administration inadequate, she designed and developed a bassinet-size oxygen tent that could be cooled with dry ice.

During depression days, when she was taking a postgraduate course in medical nursing at City Hospital in St. Louis, Miss Buechel became convinced that many of the hypodermic needles which were being discarded could be salvaged if a means could be found to sharpen them. Characteristically, she set



NEEDLE CLEANER

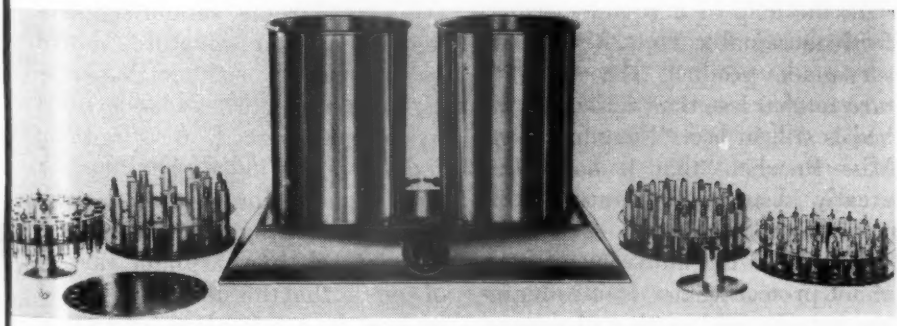
about solving the problem herself.

From a friendly jeweler she learned about the various polishing stones used in his trade, and obtained, through him, some of the materials necessary to construct a simple sharpener. In developing the device, she discovered that the tedious job of cleaning needles was far more time-consuming than that of sharpening them; a mechanical cleaner, therefore, seemed also to be called for. So why not combine the two in one labor-saving unit?

At a cost of $35, and with the help of the hospital's maintenance department, she rigged up a working model which was operated by pressure supplied by an asepto bulb. The idea was basically sound, but the bulb pressure, unfortunately, wasn't sufficient to make the cleaner function properly.

Various jobs in other hospitals ensued, and the invention was temporarily put aside. Eventually, Miss Buechel found herself working in an oxygen department; and here, remembering the needle cleaner, she suddenly realized that it might well be made to work if the pressure were supplied by oxygen (or some other gas). Experiments proved the practicability of the idea; and with the development of an improved model, utilizing either nitrogen, carbon dioxide, or compressed air, she was able to obtain her first patent.

The inventive-minded nurse has since developed and patented a number of other hospital items—some as a result of her experience in improvising necessary equipment in the various central supply departments which she has helped to set up. These inventions include a drainage bottle-holder, which enables a hospital to use its empty (and often-discarded) I.V. solution containers instead of buying drain-



SYRINGE CLEANER

age flasks; an effective rubber-glove tester, operable by either compressed air, oxygen, nitrogen, or carbon dioxide, which eliminates hand-testing; and also a time-saving, easy-to-use hypodermic syringe cleaner, which employs compressed air to agitate the suds and thus minimizes the amount of detergent required.

In 1944, while taking another graduate course in nursing procedures and techniques at the University of Pittsburgh, Miss Buechel wrote and published an article explaining a new technique for the administration of hypodermics. Her suggested method, she reports, has since been adopted by several hospitals.

In 1948, when her mother was hospitalized for several months with a serious vascular ailment, the use of an oscillating bed became necessary, and the patient was advised to obtain one for home use after her discharge. Since the cost involved was considerable, Pauline put her mechanical skill to work to fashion a homemade version; and by the time her mother was brought home, the R.N. had constructed—with the help of a friend— a perfectly acceptable copy of the factory-made product. Her expenditure totaled less than $240 and the bed is still in use. "I'm sure," says Miss Buechel "that it has aided greatly in preventing further vascular trouble."

How does the nurse-inventor go about protecting her ideas, obtaining patents, and getting placement

GLOVE TESTER

for her inventions on the market.

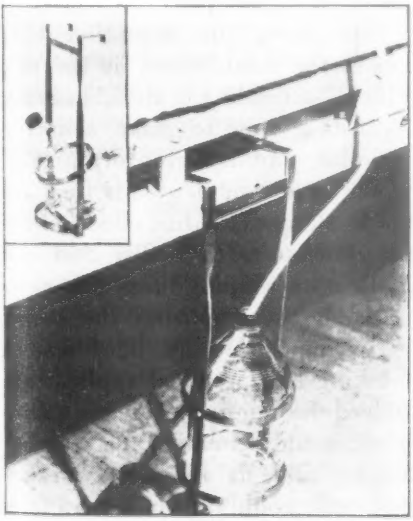
"Most manufacturers," she explains, "refuse to look at an invention until they're sure that the inventor has legally protected himself. This involves important steps.

"Let's assume, for example, that you've envisioned a new kind of adjustable backrest for bedfast patients. The first thing to do is draw up a detailed document explaining in text and drawings exactly how the backrest would work, how it would be constructed, and so on. Two witnesses, who really understand the idea, and who are not relatives of yours, should sign this document; their signatures should be preceded by some such phrase as, 'Explained to and understood by the undersigned.' *Be sure these signatures are dated.* Then have a notary public impress his seal on the pages so that it overlaps the drawings. It goes without saying, of course, that this document should be kept in a safe place with other

valuable papers that you may have.

"Your second step involves a trip to the public library for a check on what is called 'prior art'; in other words, you should familiarize yourself with all published information about devices similar to the backrest you have in mind. Obviously, it would be folly to waste time and money perfecting an idea which already has been developed.

Such standard indexes as the *Industrial Arts Index*, the *United States Catalog*, and the *Readers' Guide to Periodical Literature* will help you to run down published articles on any given subject within recent years; and by scanning the articles, you can decide whether or not to go ahead with your project. Before you proceed, however, you should also have a reputable patent attorney make a thorough search of the records to be sure that your idea is patentable; for a moderate fee (usually about $25), he will furnish you with copies of patents most similar to your own projected scheme.



DRAINAGE BOTTLE HOLDER

"You are now faced with the actual development of a working model. It need not be 100 per cent perfect so far as appearance goes, but it should at least be free of mechanical flaws, flimsiness, and other obvious defects; in other words, it should be tested thoroughly to be sure that it will do the job it is intended to do. To protect yourself legally during this period, keep a daily record of your work and have it attested to by reliable witnesses.

"When you are fully satisfied that your device is practical from a construction and usage standpoint, your patent attorney will assist you in filing an application for a patent. Text and drawings, prepared exactly in accordance with Patent Office rules, must be submitted to the government authorities, together with a filing fee of $130. If your application is found to be in order, it is passed along to a patent examiner, who will notify you—eventually—whether or not your request is 'allowable.' Don't be impatient if his decision isn't presently forthcoming; inventors usually have to wait several years to receive a favorable reply.

"A favorable finding means that your patent will be issued upon the payment of a final fee of $30. This patent—which is not renewable—gives you the right, for seventeen years, to 'exclude others from mak-

ing, using, or selling the invention throughout the United States.' If the examiner's decision is unfavorable, you will be told why; whereupon your attorney and the examiner may try to reach an agreement. Failing that, you have the right to request an appeal.

"Although you need not wait for the issuance of the patent to go ahead with the marketing of your invention, it is wise to have filed your application. The marketing job, of course, calls for salesmanship; but three ways in which to proceed are open to you:

"1. You can manufacture and sell the device yourself as an independent operator. To do this, you must have plenty of capital as well as the know-how of the able businessman; and while the potential profits may thus be greatest, so too is the risk involved.

"2. You can license the manufacture and sale of your invention on a royalty basis. In so doing, you can hope to receive about 5 per cent of the wholesale price.

"3. You can sell your patent rights outright to anyone—an individual, a small company, or a large corporation. This procedure is often the easiest and safest, but usually the least profitable.

"To obtain a list of manufacturers who might be interested in your invention, consult the *Thomas Directory of American Manufacturers* (and similar reference books) at your public library. Then write a letter to several of the more promising prospects on your list briefly outlining the purpose of your invention and its principal features. If the idea seems to have possibilities, you will probably be offered an appointment and the chance to demonstrate your working model. Should nothing but turndowns result, write to others on your list.

"Statistics regarding the success of inventions are rather discouraging; only about 5 per cent repay even the patent costs. Invention-for-profit is a tough game, generally speaking. The devices which have made the most money are those that (1) fill a need, but are simple and easy to make; (2) can be used without requiring people to change their routine habits; (3) can be made and marketed by a 'going' concern; (4) have a relatively short life, with a chance for many repeat orders; and (5) sell at a lower price than competitive devices, or have advantages which justify a higher price.

"In short, the invention that makes the most money is the one which—according to the old saying—'costs a dime to make, sells for a dollar, and is habit-forming!' "

Old saying or new, this final remark stamps Pauline Buechel as the down-to-earth realist that she is. Bent on shaping ideas into realities, she accomplishes the seemingly impossible by hard-headed thinking and practical application. Indeed the nursing profession as a whole could benefit by her fine example; and its research workers especially could do worse than take a leaf from her book.

SCIENCE SHORTS

♥A substance, streptokinase-streptodornase, produced by streptococcal bacteria, is effective in dissolving blood vessel clots, according to Dr. Mario Stefanini of Boston. Anticoagulants, it was noted, may prevent clot formation, but cannot reduce the size of an already existing clot.

♥*An operation, reported by two University of Maryland doctors, helped five out of six patients incapacitated by angina pectoris by cutting all branches of the vagus nerve leading to the heart.*

♥Mecamylamine, a new nerve-blocking drug for hypertension, was described by Dr. John H. Moyer of Baylor University as the first oral ganglionic-blocking drug completely absorbed from the intestinal tract. The drug was said to be more effective when used with rauwolfia serpentina.

♥*Trying to produce more animals with heart disease for study, Louisiana State University scientists found that over half the offspring of pregnant rats injected with trypan blue had many heart defects.*

♥Some forty-three children have undergone heart surgery with controlled cross circulation, a technique developed at the University of Minnesota which permits a clear, bloodless view of the heart. To bypass the heart, blood is pumped from the patient's veins to a donor's lungs, or to reservoirs of oxygen-rich blood, for oxygenation.

♥*Excellent results in almost all seventy-five cases in which artery grafts were used to restore blood flow to arteriosclerotic legs were reported recently by Dr. Michael E. DeBakey of Baylor University.*

♥In reviewing the first 150 patients using artery transplants supplied by the New York Blood Vessel Bank, Dr. Edward B. C. Keefer of New York Hospital-Cornell Medical Center pointed out that, among other uses, transplants can now take over functions of vital arteries removed because of cancer.

♥*Carefully controlled, year-long tests at Iowa State University showed that rauwolfia benefited fourteen out of fifteen patients suffering from coronary heart disease and angina pectoris.*

♥National Institutes of Health scientists found that heart muscle of animals given stress tests after induced heart attacks had unusual reserve strength. After the first six hours following coronary occlusion, there was no significant difference in exercise tolerance between rats with damaged hearts and normal rats.

When She *Chooses* Natural Childbirth

What obstetrical nurses should know about these patients who have trained for childbirth.

by V. Jeanne Creger
and
Mabel L. Fitzhugh

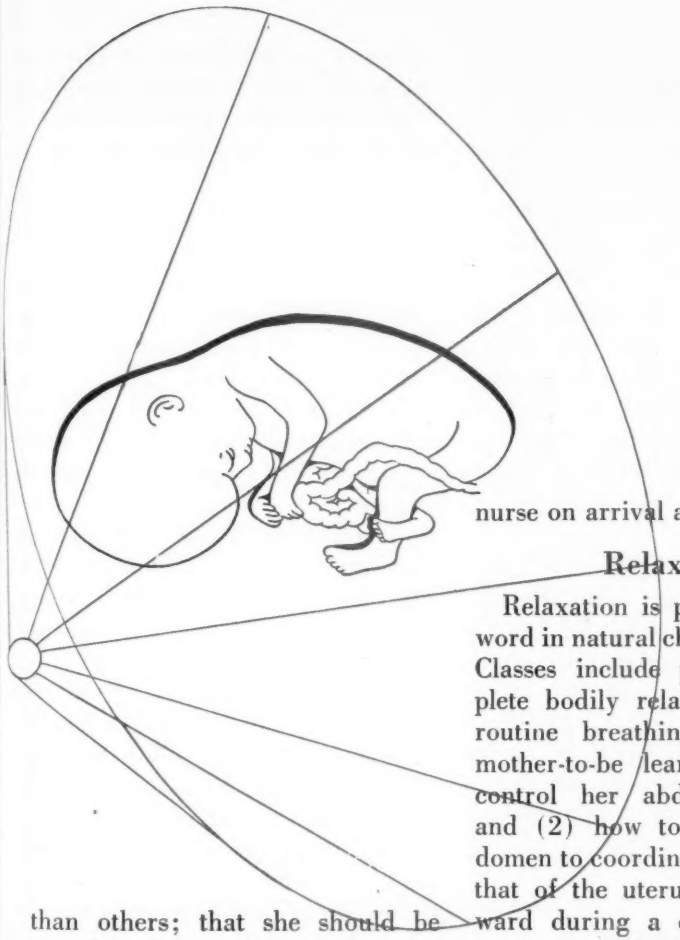
"WE handle maternity patients with the same assembly-line technique that has proved so efficient in turning out motor cars. It is a sad commentary on our sense of values that we inflict this on sensitive young women going through the supreme experience of their lives."

So states Dr. Nicholson J. Eastman, obstetrician-in-chief at Johns Hopkins Hospital. His opinion is shared by the proponents of natural childbirth who believe that the maternity patient should always be treated as an individual undergoing a normal biological process.

Despite the "assembly-line technique," however, natural childbirth is gradually gaining ground. Maternity classes based on this principle are now conducted in many communities under the auspices of hospitals, YWCA's, adult education groups, and private obstetrical practitioners.

Because of this growing interest, nurses should know what is being taught in these classes so that they will be better able to assist the woman who has had such special training. This woman will need a different kind of supervision during labor and delivery—different from that needed by the patient who knows nothing about childbirth, or by the one to whom childbirth means only agony.

For example, when a woman says she is going to have a "natural" delivery, the nurse must be able to convince her that her goal should be a *satisfying* birth—not necessarily a drugless one. The patient should be told that no two deliveries are exactly alike: that some cervices dilate more easily



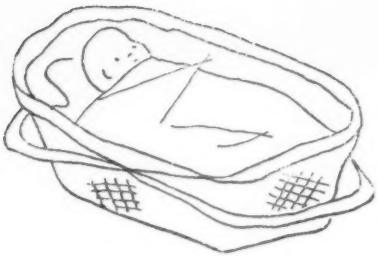
than others; that she should be grateful for medication if she needs it, inasmuch as it may help her to relax and perhaps have her baby faster; that the period of real pain is very short at the end of the first stage if one is able to keep relaxed up to that time.

Experience indicates that women who have attended classes may dilate faster than untrained women. The labor nurse, naturally, needs to know what to expect: hence, the floor nurse should remind her trained patient to make her attendance at special classes known to the nurse on arrival at the labor room.

Relaxation

Relaxation is probably the keyword in natural childbirth training. Classes include practice in complete bodily relaxation. Through routine breathing exercises, the mother-to-be learns (1) how to control her abdominal muscles, and (2) how to expand her abdomen to coordinate its action with that of the uterus in tipping forward during a contraction. The cervix receives its impulse to relax through the sympathetic system.

During the first two-thirds (or even four-fifths) of active labor, the trained mother lies quietly, apparently asleep. Noting her breathing, one sees no chest movement at all—simply a smooth, rhythmic, gentle expansion and relaxation of the abdominal wall. At intervals, the expansion is slowly increased, and short, wave-like movements may be seen on the surface of the expanded wall. Then there is a slow release, and the con-



traction is over. No strain is seen on the mother's face, not even a concentration of effort. Nurses seeing this phenomenon for the first time refuse to believe that the mother is actually in labor, despite the evidence of the hand on the abdomen.

Even greater emphasis on relaxation may be seen when the late, strong contractions begin, for it is in this stage that relaxation usually makes the pain and discomfort bearable. There is a sharp contrast between the relaxed, trained mother and the woman who doesn't realize that moving or screaming tightens muscles which should be relaxed and expanding.

Positioning

Nurses familiar with natural childbirth principles have been able to teach untrained mothers ways of relaxing during labor. For example, a nurse may advise a change from the supine position with legs extended to a similar position with knees flexed, lower jaw sagging, and hands limp. When one lies perfectly still, letting the breath out completely during a contraction, or panting slightly, one does not fight the pain.

The position of greatest comfort during the latter part of the first stage of labor varies in women of different build. Also, the position of the baby may determine which side to lie on. One tall woman found she was most comfortable sitting with knees out and soles together, and with the back of the bed raised to support her. During a contraction she leaned forward a little with her head down. Some women prefer to sit in a comfortable chair with knees spread wide.

Rarely is a maternity patient comfortable lying on her back with only a medium pillow; the angle of support should be adequate to give maximum comfort. The knees should be flexed, thighs outwardly rotated and supported by pillows, for complete relaxation of the pelvic area. The bed should be flat for side-lying. A large pillow between the knees, and a small pillow or folded bath towel under the side of the abdomen, may give added comfort. Pain in the low back is relieved by firm pressure or massage during a contraction.

In a long labor, it is well to change the patient's position occasionally, but never just before or during a contraction. A modified knee-chest position with a large pillow under the chest may be a welcome change. Gravity then aids in the forward movement of the uterus, and back pain may be relieved.

Panti[illegible]

An important part of childbirth training is practice in the deep panting that must be used when

there is a need for delay in delivering the baby. This type of panting must not be confused with the light, upper-chest panting often used to slow down pushing during the end of the second stage. Panting—a much safer technique than heavy medication—needs to be understood by the mother. One patient described it in this way: "I panted like a Great Dane, with heaving shoulders."

Position During Delivery

The delivery-table position of the conscious, cooperative woman requires more attention than that of the heavily anesthetized one. To make full use of expulsive contractions, she needs to be propped in a position that will give her back a simple round curve instead of a double curve with the lumbar spine arched. After experimentation with several propping pillows, and one large, especially made pillow, an adjustable backrest was devised. Bolted to the delivery table under the pad, it lies flat and invisible when not in use.

The propped position relieves low-back strain and helps the mother push in the right direction. It also enables her to relax her pelvic floor muscles more easily. In certain cases, a folded bath towel tucked under the sacrum gives added comfort.

Proper support of the legs is essential for relaxation and comfort between contractions. A stirrup supporting the calves should be adjusted to hold them securely without exerting pressure under the knees. Left and right leg supports should not be too far apart, for continuous strain in the adductors of the thighs makes it difficult to relax the pelvic floor.

If an obstetrician prefers not to use stirrups, the patient's knees should be supported by an attendant during and between contractions to prevent unnecessary fatigue and shaking. Hand grips on the table allow slight flexion of elbows. It should not be taken for granted that the delivery set-up is all right: between contractions, the patient should be asked if she is comfortable.

The Delivery

When gas is used and the mother is instructed to bear down, it is better to take the mask off while she is holding her breath and pushing. Her head needs to be up and forward, so that the abdominal muscles may contract fully in the expulsive phase. Oxygen can be given between contractions as directed. If the patient says she doesn't need gas, and her doctor agrees, the nurse should act accordingly. The mask would only obstruct the patient's view of the birth in the mirror before her.

Emotions During Labor

The effect of the emotions on the progress of labor in a conscious woman cannot be underestimated. Therefore, the attitude and conversation of those in the labor and delivery rooms should encourage

confidence and relaxation. Medical students, interns, and nurses should not make careless remarks within earshot of the patient.

Direct conversation can also be misinterpreted. For example, one should never say to a woman in labor, "Oh, you'll have hours and hours of these pains before you have your baby." Rather, the comment should be, "You did very well with that last contraction. If you keep on relaxing it won't be too long." (Indeed, the phrase "labor pains" could well be omitted from obstetrical teaching and the word "contractions" could be used instead.)

The mother who has seen the Birth Atlas, and who understands the effort the uterus must make to push the baby through the cervix, is usually able to withstand the real pain with a minimum of medication or none, especially if her husband or a trained attendant is with her, so that they can keep reminding her to relax.

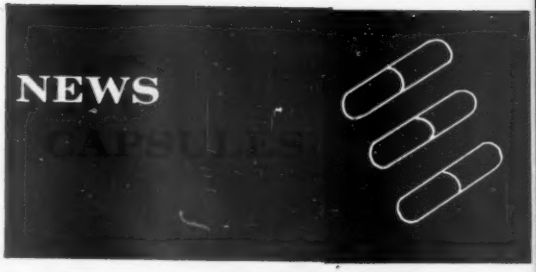
During the last half-hour of the first stage of labor, a patient needs "the right person" with her. Psychologically and emotionally, her husband is the best possible companion. Going through this experience together may have far-reaching effects on the stability of their marriage. If the husband cannot be present, a trained labor nurse, or the nurse who taught her class in childbirth, should remain with the patient.

The trained husband helps to time contractions, notifying the nurse of the change in their frequency or duration; a change which signals the approach of the second stage. He acts as his wife's "coach," cheering her on, reminding her to relax, placing his hand on her abdomen to focus her mind and efforts on the expansion of the muscles.

Fortunately, nature is kind to parturient women. There is a natural "amnesia," experienced by many women who require no medication, which makes contractions easy to bear. In fact, some feel no pain in the second stage, and rather enjoy the pushing. On the other hand, those expecting no pain at all may become panicky and require heavy sedation.

Pain, however, is soon forgotten by the unsedated mother in the climactic, joyous moment following delivery. In certain hospitals, the doctor holds the baby up so that the mother and the father—if he is allowed in the delivery room—can make the sex discovery themselves. It is then that the nurse can praise the baby, admiring the dimple in a little girl's chin, or the full chest of a boy, or whatever else may intrigue her.

The personal satisfaction of those who are able to guide a woman through a normal, consciously cooperative delivery—watching the ecstasy on her face and hearing the triumphant thrill in her voice as she sees her child delivered and hears its first cry—is not to be compared with any other satisfaction in our profession.



NEWS New York's State Nurses Association has authorized a fee boost, effective July 1, enabling private duty nurses in the Manhattan, Bronx, and Staten Island sections of New York City to raise their rates from $14 to $16 for an 8-hour day. At the same time, hospitals in the three counties will be asked to raise the starting pay of general duty nurses from $3,120 to $3,500 a year.

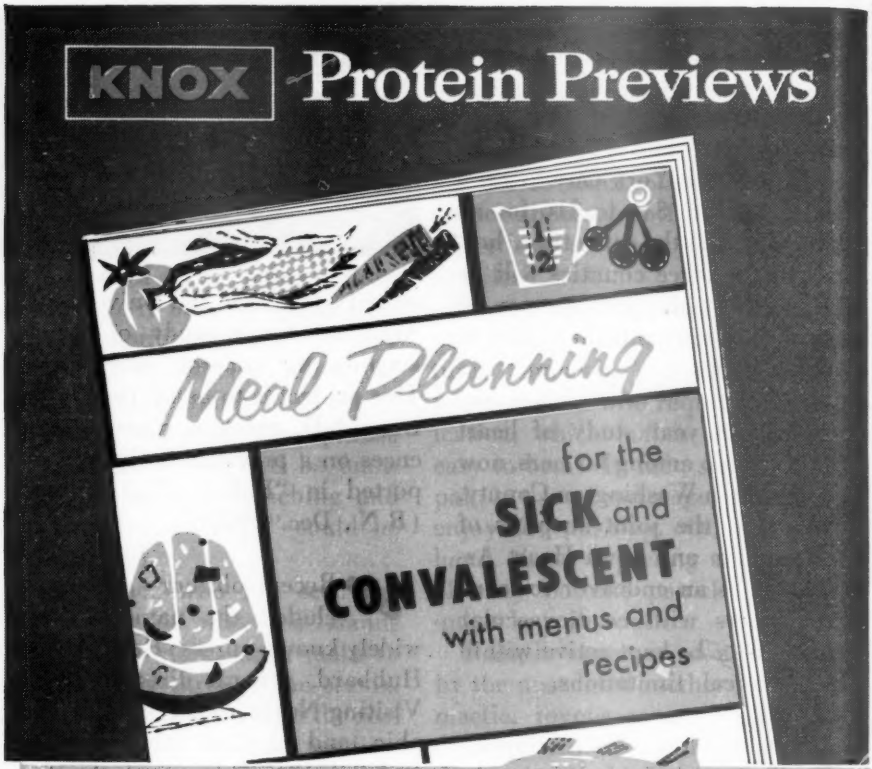
NEWS A one-year study of heart disease among farmers, now being made in Washington County, Iowa, under the joint auspices of the American and Iowa Heart Associations, is an endeavor to learn how farmers with cardiovascular ailments may be kept active within their physical limitations.

NEWS Baptist Memorial, Memphis, Tenn., has joined the ranks of the relatively few hospitals offering postgraduate assistance to their R.N.'s. The BMH plan covers full tuition for courses completed by any staff nurse who is either a BMH graduate or has been with the hospital for at least a year.

NEWS Eleven grants-in-aid for research aimed at improving hospital efficiency were scheduled to be announced by the Public Health Service around Jan. 1, according to *Washington Report on the Medical Sciences*. The grants, totaling $401,960 and the first of their kind to be made under Hill-Burton Act provisions, included one of $14,850 to the University of Arkansas for a study of record-keeping by general duty nurses. This project is to be carried out by Donald D. Stewart, whose experiences on a previous study were reported in "Follow That Nurse!" (R.N., Dec. 1955).

NEWS Recent obituary notices included the names of two widely known nurses: Ruth Weaver Hubbard, general director of the Visiting Nurse Society of Philadelphia, and Lt. Col. (retired) Utie I. Kleibscheidel, one of the first Army nurses to go overseas in World War I.

NEWS *Dorothy M. Smith*, formerly assistant director at the Hartford (Conn.) Hospital School of Nursing, has been appointed dean of the new college of nursing which opens next fall at the University of Florida . . . *1st Lt. Betty J. McKim*, ANC, is the author of a recently published book of poems titled "Dudley's Dream" . . . *Margaret Metzger* has been named to Colorado's State Board of Nurse Examiners . . . *Helen C. Owens* is the new director of nursing services at the Long [*Continued on page* 80]



New Booklet Presents Latest Facts on Feeding the Sick

Nurses often must devote much time to describing good nutritional practices.

"Meal Planning for the Sick and Convalescent" relieves you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents the latest nutritional applications of proteins, vitamins and minerals, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. It offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

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CANDID COMMENTS

[*Continued from page 42*]

expect a "second wind," consequently, both individuals and society were caught short by the extended life span. But the *rising* generation does know with reasonable certainty that there is a considerable stretch of life ahead. Young people must build sound foundations; they must build *expandable* lives, "adding something from every paycheck."

The new horizons are not only of time but of space, and we must build accordingly. The higher the building, the firmer must be its foundations. The early generations of nurses lived restricted, intensive lives, always with the ill. Today's generation literally goes everywhere, not only to help the ill but to bring hope and life in preventing disease and promoting health. Nursing exists to meet human needs—a wonderful, expanding thing in itself.

Nursing is a "natural" on which to build a good life anywhere because it provides disciplines, skills, ability to meet the unexpected, and an insight into and love for people. The very democracy of its service adds to its strength. The foundation is down. The walls will be built brick by brick through experience, learning, and attitudes.

Thus we can come to look on every day (no matter how many) as an adventure, and at its end thank God for the privilege of life.

EDITORIAL

[*Continued from page 33*]

who talk about and appreciate the size and effectiveness of the x-ray machines, the efficiency of the pathology departments, the shadowless lights in surgery. Patients talk about, but don't appreciate: unanswered lights; remote-control nursing; cold, unpalatable food; and subprofessional, assembly-line care given by ill-prepared, poorly paid incompetents.

The quality of hospitalization will always be rated by humanistic rather than materialistic factors, regardless of the expenditure on edifices and new equipment. In patients' minds, the human considerations will always rate far above mere masonry.

Voluntary nonprofit hospitals have been advanced many years by this unexpected financial windfall. They are now in the enviable position to inaugurate a program of genuine self-improvement. For many, the pessimism of goals-too-far-removed can be a thing of the past. With this impetus provided by the Ford Foundation, the over-mortgaged, under-financed hospitals can, at last, permit their administrators to act like human beings again, sensitive to the problems that they in their dilemma have helped to create. And, possibly, current operating expenses may not loom so large when future necessities and goals come within the realm of financial reality.

—Alice R. Clarke, Editor

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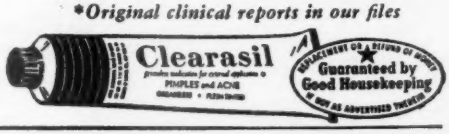

RHEUMATIC HEART

[*Continued from page 53*]

patient's heart while the blood is shunted around it during an operation. This permits the surgeon to work for long periods in a nearly bloodless heart while the blood is in the process of being oxygenated and pumped mechanically.

While all these dramatic developments have already helped thousands, perhaps the most important innovations in the fight against rheumatic heart disease have taken place in preventive medicine. Practical means are presently at hand for preventing rheumatic fever and reducing its incidence among susceptible children.

Statistical studies have shown that prompt treatment of streptococcal tonsillitis and nasopharyngitis with penicillin is capable of reducing rheumatic fever cases to about one-fifteenth of what may normally be expected. As a result of such studies, a number of communities have set up prevention programs in which parents, teachers, nurses, and public health authorities are working together to detect and treat all streptococcal sore throats in school children.

A child arriving at school with a sore throat, fever, or other signs of respiratory infection is sent to see the school nurse. She takes the child's temperature and a throat culture. If the temperature is elevated, the nurse informs the mother that the child should be put

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Children's Size Super Anahist contains clinically proved thonzylamine hydrochloride (best known and safest antihistamine), plus APC compound . . . in half the adult dosage for fast, effective relief of sniffles, sneezing, headache, muscular aches and pains of colds.

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to bed. Later, if the culture proves positive, the nurse may notify the parents and urge them to consult the family physician. The doctor can then initiate intensive penicillin therapy, beginning with an intramuscular injection of one of the newer, long-acting, "depot" forms of the drug and following it up for ten days with oral doses three or four times daily. Finally, in many cases, the local health agencies make follow-up visits to the home to check on whether the child is getting the medication or suffering any reaction from it.

While such programs for eradicating streptococci before they get started are proving successful, prophylaxis is of even greater importance in those who have already had one or more attacks of rheumatic fever. Studies indicate that the incidence of new attacks following streptococcal infections is much higher in youngsters with a history of the disease. And such recurrences greatly increase the likelihood of serious damage to the heart.

This has led to the concept that rheumatic activity smoldering persistently in these children may be set off periodically by streptococcal infection. To prevent such flare-ups, it has been suggested that all youngsters who have had rheumatic fever should receive long-term prophylactic penicillin therapy. According to those who advocate this measure, oral penicillin should be administered daily, winter and summer, throughout childhood and even after the age of 18. Such treatment seems to be relatively safe and effective; allergic reactions to penicillin are rare, and the hemolytic streptococcus does not appear to become resistant to it, as do other bacteria.

But the child who has suffered a severe attack needs much more than drugs. Because the residual effects last for many months, a prolonged convalescent period is necessary. During this time, the child requires a great deal of specialized care, including intelligent, sympathetic nursing. The alert nurse tends not only to the child's physical needs but also to the emotional factors that may tend to impair recovery. Together with parents, teachers, and occupational therapists, the nurse must work to provide an emotional environment in which the child can thrive and achieve mental health as well as physical well-being. The parents, too, need the nurse's help in overcoming anxiety and learning to accept the child's illness realistically as well as optimistically.

Hope is high among those who are carrying on the fight against rheumatic heart disease. Improvements in hygiene and in the general standard of living have already done much. Routine prophylaxis should help to lower the incidence of streptococcal infections and rheumatic fever in the future. And continued research may bear fruit at any time in the form of new drugs to prevent the disease in susceptible children.

CONVALESCENT CARE

[*Continued from page 38*]

hospital costs—is its generous provision of free care for the women referred by physicians from nearby hospitals. (A visit to this unique home is scheduled for report in our next issue.)

In addition to homes operated on a non-profit basis, there are a vast number operated for profit, several of which embody the latest in modern convalescent concepts. Others, like some hospital convalescent units, are merely custodial boarding homes.

Unfortunately, there are still plenty of substandard convalescent homes, and too many are found in the profit-making category. In these homes, there is no knowledge of the value of continuity of medical care nor of rehabilitation. In fact, some are not convalescent homes at all, but nursing homes admitting convalescents as well as the chronically ill. Convalescent and chronic hospitals are listed together in American Hospital Association statistics, and state licensing laws do not distinguish one type of home from another.

A brief backward look helps to explain this confusion. The nursing home movement had its big push in 1935 when enactment of Social Security permitted more old people to pay something for their care. Uncontrolled by licensing laws and, in many cases, developed as money-making schemes, the homes—rest homes, boarding homes, homes for incurables, convalescent homes, or what you will—multiplied rapidly. Today it is estimated there are about 8,900 such homes caring for, or housing, about 170,000 people.

Slowly, the public is being forced by its own needs and sense of decency to do something about the upgrading and formulation of standards for these homes; the message of rehabilitation is also seeping through community consciousness. There is an encouraging increase in the number of states adopting statutes licensing nursing homes, which means that health and sanitation standards as well as other requirements, such as adequate professional nurse-staff-

ing, must then be complied with.

However, there are still drawbacks to progress. And unhappily, one of these drawbacks is the inertia of organized nursing in stimulating interest in higher standards of nursing care, not only for convalescent patients but for all occupants of nursing homes. If, as one authority has suggested, the day comes when nursing-home care assumes as much importance as hospital care, organized nursing will have had little professional part in achieving this goal.

The exact path that convalescent care will follow in the future is uncertain. But it's safe to say that the subject will receive increasing emphasis. Some government stimulus has already been given by new Hill-Burton regulations providing matching grants for nursing homes and vocational rehabilitation facilities associated with hospitals. A considerable financial boost is the recent liberal provision of Ford Foundation funds for extension of services in certain convalescent homes. Another possible stimulant may be the extension of Blue Cross plans to cover short-term convalescent periods.

But whatever the course of convalescent care, there's bound to be experimentation, not only in financing but also in architecture and staffing. One doctor, in advocating convalescent centers as an answer to the problems of inadequate hospital beds and high cost of hospital construction and maintenance, envisions them as one-story structures, staffed by practical nurses with one or two supervising trained nurses. He suggests such other features as motor court style architecture with a central dining room, a suburban location, and family-doctor-supervision.

It's not farfetched to believe that Miss Nightingale would be pleased if she could see her recommendation, made in 1863, being considered so seriously by this country's hospital and medical authorities in 1956. However, she would probably count it a double blessing if organized nursing added the weight of its professional counsel to the still distant goal of better convalescent care.

IDEA OF THE MONTH

[*Continued from page* 45]

individual nurse could care for, the more money she could earn.)

(2) The plan would enhance the dignity of bedside nursing. Patients paying for care on a fee basis would come to recognize nursing as a profession in its own right—not as a by-product of hospital service.

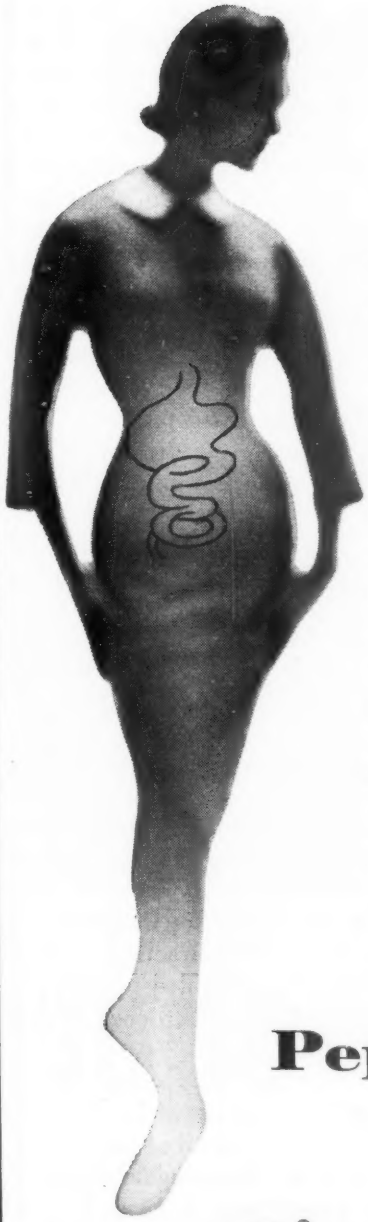
(3) The individual nurse would be encouraged to give better care, knowing that she is directly responsible to the patient who is paying her. At present, she may easily be inclined to act as if responsible to the hospital (her employer), rather than to the patient.

(4) Instead of promoting the "assembly-line" concept (whereby one nurse gives baths, another takes temperatures, a third administers medications, and so on), the proposed plan would promote the concept of "total care" by one fully responsible R.N. In other words, such a nurse would have her rightful chance to evaluate each patient's progress and to administer to his psychological as well as his physical needs.

(5) The nurse's earnings would be such that she would no longer be dependent upon the hospital for vacation and time-off pay; a further help in reducing hospital costs.

I believe these advantages to be mighty important ones—factors which make the plan worthy of consideration and experiment. True, it might give rise to certain problems. Such problems, however, are largely matters of detail which would have to be worked out; they do not in themselves preclude the over-all feasibility of the idea. If we stand united in our endeavor to keep the dignity of bedside nursing, we can surely make this plan (or some modification of it) work to the advantage of all.

COPIES of a cumulative index for R.N., *January through December, 1955, will be off the press shortly and may be obtained free, upon request. Please send your request to: Editorial Department,* R.N.—*a journal for nurses, Oradell, N.J. Requests will be filled while supplies last. Some 1953 and 1954 indexes are still available.*



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ANOTHER FINE Norwich® PRODUCT

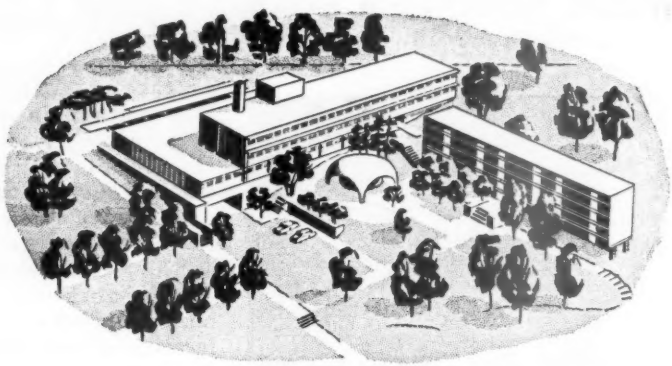
NEWS

[*Continued from page 67*]

Beach (New York) Memorial Hospital . . . *Mrs. Rhea P. Steele*, treasurer of the Iowa Association of Nurse Anesthetists and an amateur movie photographer of note, has produced a documentary color film called "Cæsarean Sections" which has been shown to professional groups in San Francisco, Memphis, Des Moines, Chicago, and Washington, D.C. . . . *Emma Kuehlthau* has been appointed executive director of Milwaukee's Visiting Nurse Association . . . *Mrs. Ruby Wilities* of Bradley, W. Va., is credited with rescuing a doe in labor from an attack by an angry bull. The doe thereupon delivered twin fawns . . . *2nd Lt. Weldon J. Bishop*, the second male nurse to be commissioned by the Army, has been assigned to Brooke Army Medical Center, San Antonio, Tex.

NEWS National Health Council's 1956 forum meets March 21 at the Sheraton-Astor Hotel, New York City, for a two-day conference on chronic illness . . . The annual convention of the National Association for Practical Nurse Education is scheduled for May 7-11 at the Edgewater Beach Hotel, Chicago.

NEWS New address of the International Council of Nurses and the Florence Nightingale International Foundation: 1, Dean Trench St., Westminster, London, S.W.I.



OPPORTUNITIES ARE WAITING IN AMERICA'S MOST TALKED-ABOUT HOSPITALS

NURSES

Excitement has been running high since it became known that 10 new hospitals were being built in the coal fields. These hospitals ARE different—in structure, in design—and most important, in organization. Everybody in the Memorial Hospitals is part of a new, dynamic medical care team. Opportunities of major significance are waiting for nurses who become part of that team. Monthly salaries for team leaders begin at $405 for a forty-hour week. Shift differentials, salary increases and a no-expense retirement plan are just some of the benefits provided.

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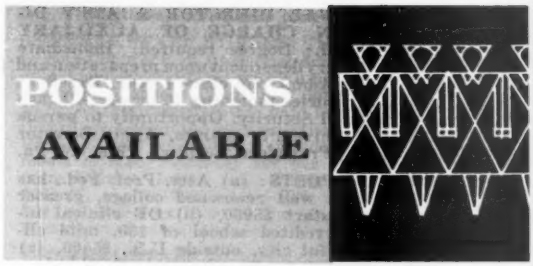

ADMINISTRATORS: (a) Small, modern hosp., well organized English-speaking staff, cosmopolitan city, outside U.S., free housing, transportation. (b) New 35-bed hosp., full complement of nurses, attractive college town, Wisconsin, $5000. RN 2-1 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

AMERICAN RED CROSS REPRESENTATIVES: Excellent employment opportunities for nurses, ages 26-48, as traveling nursing representatives. Positions entail teaching, supervision and community organization responsibilities. Qualifications: Bachelor's Degree in public health nursing or nursing education, plus supervisory experience. Openings available in the Midwestern and Western sections of the country. Periodic salary increases, liberal leave policy, retirement system, plus Social Security benefits and group insurance plan. Direct inquiries to Mr. Norman A. Durfee, National Director, Personnel Services, American National Red Cross, Washington 13, D.C.

ANESTHETISTS: (a) Outside U.S.A., modern, air-conditioned, 300-bed hosp. for employees of American oil company, $10,000. (b) Staff, large, modernly equipped dept. under M.D., 200-bed hosp., wealthy suburban area, MW. $6000. (c) Percentage or fee basis, 40-bed, new hosp. near Mexico Border. (d) Head staff of 2, new 70-bed hosp., opens March, scenic resort area, $6600. (e) Staff, 75-bed hosp., beautiful ocean city, Florida. (f) Staff, excellent working conditions, 200-bed genl. hosp., univ. city, Calif., $5200. (g) Anesthetist; small, genl. hosp., coastal city, Alaska, $6000. RN 2-2 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

ANESTHETIST-NURSE: 60 bed general hospital, new building, modern equipment, western Wisconsin, college town. Vacation, sick leave, retirement plan. Apply to H.C. Guntner, Manager, Memorial Hospital, Menomonie, Wis.

ANESTHETISTS: A.A.N.A. member. 250 bed general hospital, salary open, automatic increases, laundry provided, 40 hr. week, no obstetrics, liberal vacation and personnel policies, Social Security. Sutter Hospital, Sacramento, Calif.

ASS'T CLINICAL INSTRUCTOR: Surgical Nursing. 3 yr diploma program. 518 bed hospital, approximately 240 students. B.S. Degree in nursing required. Experience preferred. Position available immediately. Salary commensurate with qualifications. Write Director of Nursing Education, St. Luke's Hospital, 11311 Shaker Blvd., Cleveland 4, Ohio

ASS'T DIRECTOR NURSING SERVICE: Opportunity for a young, energetic nurse with supervisory experience who intends to make nursing a career. Position in 365 bed hospital requires a Masters Degree, preferably in nursing administration. Suburban living in metropolitan New York City area. Salary open. Box HH-1 c/o R.N. Magazine, Oradell, N.J.

CENTRAL SUPPLY SUPERVISOR: Capable of handling a new and exceedingly busy Central Supply Dept. in 271 bed hospital in residential suburb of Chicago. Strong basic knowledge required. 40 hr wk, cash salary $350 to $400 per mo, living accommodations for single nurse in beautiful nurses' residence. Low rental apartment for married nurse. 2 to 4 wks vacation, 6 paid holidays, sick leave policy, free life insurance, plus other benefits. Apply Personnel Director, MacNeal Memorial Hospital, Berwyn, Ill.

CLINICAL INSTRUCTORS: Positions open in medical, surgical and obstetric divisions. 3 yr. diploma school expanding to prepare for national accreditation. Salary range $325-$425 depending upon education and experience. Liberal personnel policies, 1 mo vacation. In Santa Clara Valley, 50 miles south of San Francisco. Write Director, O'Connor Hospital School of Nursing, San Jose, Calif.

DENVER COLORADO JOB OPPORTUNITIES: Staff nurses for 417 bed general hospital with school of nursing. Full or part time. Choice of working 5 or 5½ day week. Going salary for Rocky Mountain Region, bonus for evening and night duty. Paid sick leave, vacations and holidays, Social Security benefits. Some housing available or we will assist you in finding living accommodations. Excellent opportunity for study at Denver University. Denver's climate is unsurpassed the year around. Opportunities for sports and entertainment are many. If interested wire collect for additional information or write Director of Nursing Service, St. Luke's Hospital, 601 East 19th Ave., Denver 3, Colo.

DIRECTOR OF NURSES: For 260 bed chronic disease sanitarium with probability of license increase shortly. Salary open. Joseph O. Smigel, M.D., Pinehaven Nursing Home & Sanitarium, Inc., Pinewald, N.J.

DIRECTOR-SUPERVISOR VNA: Qualified PHN with some supervisory experience. Interest in community relations and expansion of agency. Good salary. Near New York City. Write Mrs. John Papp, Jr., 42 Market St., Perth Amboy, N.J.

DIRECTORS OF NURSING: (a) Asst. Dir., 300-bed, air-conditioned hosp., American-owned company, foreign operation, $12,000. (b) Dir., school and service, 400-bed hosp., outstanding opportunity, leading univ. city, MW. (c) Dir., dual responsibility, 70 students, well organized nursing staff, suburban area of key industrial center, E, $7800. (d) Dir. nursing research, new methods, techniques, large, renowned hosp., univ. affiliation. (e) Top-notch Asst., administration and coordination of service with accredited school of 150, beautiful city, outside U.S., $8400. (f) Nurse educator, Iran (Persia), $8-10,000. (g) Dir. of nursing, 80-bed hosp., cooperative staff, mild year-round climate, attractive salary, SW. RN 2-3 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

[Turn the page]

EDUCATIONAL DIRECTOR & ASS'T DIRECTOR IN CHARGE OF AUXILIARY PERSONNEL: Degree required. Immediate opening. Salary dependent upon preparation and experience. Admit one class a year. Excellent personnel policies including 40 hr wk. All cash salary. Social Security. Opportunity to pursue additional university courses. Apply Director of Nursing, Frankford Hospital, Phila. 24, Pa.

FACULTY POSTS: (a) Asst. Prof. Ped., has 2 assistants, well renowned college, greater New York, start $5000. (b) OB clinical instructor, accredited school of 150, mild climate, beautiful city, outside U.S., $5500. (c) Asst. Instructor, Foundations of Nursing, 350-bed genl. hosp., San Francisco Bay area, $4200. (d) Director, establish nursing division, small community college affiliated with state univ. W. RN 2-4 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

GENERAL DUTY: 40 hr wk, 84 bed hospital, finest equipment, very liberal personnel policies and pleasant working environment. Must be willing to rotate shifts. Salary range $277 to $360 monthly. Atomic Energy Project but not Civil Service. Write Director of Nursing Service, Los Alamos Medical Center, Los Alamos, N.M.

GENERAL DUTY NURSES: 50 bed hospital approved by JCAH located in mountainous portion Colorado college town. Salary $275, 40 hr wk, sick leave, vacation bonus. Contact Superintendent, Community Hospital, Alamosa, Colo.

GENERAL DUTY NURSES: Opportunity to learn nursing team leadership in 400 bed general hospital, salary $290 to $310 per mo for 40 hr wk. $30 additional for evening and night duty. Uniforms are laundered free, liberal personnel policies, comfortable residence, at moderate cost. Good transportation to colleges and universities, and shopping centers. Apply Director Nursing Service, Mount Sinai Hospital, 2755 West 15th St., Chicago 8. Ill.

GENERAL DUTY NURSES: $250-$305. 165 bed approved general hospital. 2 and 3 week paid vacation. 12 days paid sick leave, 8 paid holidays. Annual raises. Board and room at nominal cost in new modern nurses' home attached to hospital. Vacancies all shifts. Apply Director of Nurses, Memorial Hospital, Cheyenne, Wyo.

GENERAL DUTY NURSES: 100 bed hospital, southern Wyoming community of 12,000. Liberal personnel policies, 40 hr. wk. Starting salary $237.50 with a charge of $22.50 for full maintenance. Additional $10 per mo. for evening and night duty with regular increases. Surgical nurses starting salary $247.50 plus $5 per call after 5 p.m. Nurses' Home recently redecorated and refurnished. Write Director of Nurses, Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY NURSES: 38 bed hospital. Prevailing salaries paid. $10 per mo. for evening and night shift, 40 hr wk. San Gorgonio Pass Memorial Hospital, Banning, Calif.

GENERAL DUTY NURSES: For a 34 bed general hospital located in a winter and summer recreational area. An accredited hospital, 40 hr wk, vacations, sick leave, holidays. Apply to Superintendent of Nurses, St. John's Hospital, Jackson, Wyo.

GENERAL DUTY NURSES: New 50 bed general hospital thriving village Catskill Mountains. Gross salary $260 mo, full maintenance available $10.50 week, other benefits. Apply Supt. Nurses, Margaretville Hospital, Margaretville, N.Y. Telephone 0501.

GENERAL DUTY NURSES: Wanted immediately for 44 bed general hospital located in Northeastern Ohio. Openings in all services. Salary depending on experience and ability, bonus for 3-11 and 11-7, 2 wks vacation after 1 yr employment, 7 legal holidays. Apply Director of Nurses, Lodi Hospital, Lodi, Ohio

GENERAL DUTY NURSES: 40 hr, 5 day wk. Salary $240 per mo plus $15 bonus for 3-11 pm or 11 pm to 7 am duty. Meal on duty, laundry of uniforms. Regular salary increases. Opportunities for advancement. Positions also available for Labor & Delivery Rooms. Located in suburban residential area near New York City. Apply Director of Nursing Service, Overlook Hospital, Summit, N.J.

GENERAL DUTY NURSES: For 500 bed general hospital in America's Most Interesting City. Liberal employee benefits including paid vacations, free Blue Cross, salary based on experience, education. Write Personnel Director, Southern Baptist Hospital, New Orleans, La.

GENERAL DUTY STAFF NURSES: 400 bed teaching hospital 25 minutes from Times

Square. Salary $250 to $280 per mo. 5 day, 40 hr wk. 4 wks vacation, 21 sick days, 7 holidays. Free Blue Cross. Social Security. Living accommodations available. Apply to Personnel Office, The Brooklyn Hospital, 121 DeKalb Ave., Brooklyn, N.Y.

GENERAL DUTY STAFF NURSE: New and modernized 300 bed general hospital offers top salaries and opportunities to advance. Evenings $76.80-$89.60 per wk, nights $73.60-$86.10, days $64.00-$75.60. Openings in Medical, Surgical, Obstetrics, Pediatrics, Operating Rooms and Emergency Room. 40 hr wk, merit increases, liberal policies. On Long Island Sound, 45 mins to N.Y.C. Modern nurses residence and school. Apply Director of Nursing, Stamford Hospital, Stamford, Conn.

GENERAL DUTY AND SURGICAL NURSES: For 271 bed general hospital in residential suburb of Chicago. 40 hr wk. Cash salary and live in: $235 day duty, $245 pm duty, $250 night duty, plus private room in new nurses' residence, 3 meals per day and free laundry of uniforms. Cash salary and live out: $275 day duty, $285 pm duty, $290 night duty plus 1 meal and free laundry of uniforms. $15 differential for surgical nurses. Low rental apartments available for married nurses. Planned service increases for nurses: $10 after 60 days and at regular intervals. Many other benefits. Write Personnel Director, MacNeal Memorial Hospital, Berwyn, Ill.

GENERAL STAFF NURSES: For 200 bed general hospital. Openings in Ped, O.B. & Med.-Surg. Minimum starting salary $255. 40 hr work wk, special consideration given for experience and qualifications. Merit increases at 6 mo, 12 mo and annually thereafter. Evening and night duty differential $10. Good personnel policies. Rooms available $20 per mo. Write Dir. of Nursing Service, Memorial Hospital, Casper, Wyo.

GENERAL STAFF NURSES: Medicine, Surgery, Obstetrics, Nursery. Beginning salary $240 with increments every 6 mos for 5 yrs. 1 meal and laundry gratis. 340 bed general hospital, near two universities, 20 minutes New York City, excellent personnel policies, 40 hr wk, overtime pay, 3 wks vacation, 4 wks after 3 yrs, sick time cumulative to 60 days. Instaff educational program, Social Security, Blue Cross available, 8 paid holidays, pleasant working surroundings. Advanced preparation encouraged. Apply Director of Nursing Service, Presbyterian Hospital, Newark 7, N.J.

GENERAL STAFF NURSES: This is a friendly place to work in preferred dept. of 200 bed JCAH general hospital with an active building program. Liberal personnel policies include 40 hr wk, retirement plan, paid hospitalization insurance premium, accumulative 30 day sick leave, 2 wks vacation, 6 holidays annually, meals at cost, rooms at $20 per mo, 40 mins. from Detroit. Initial salary evenings $336.80-$371.47, nights $322.80-$357.47, days $306.80-$341.47. For details write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

GENERAL STAFF NURSES: 270 bed general hospital and 72 bed maternity hospital. Starting salary $305 a month. $5 month tenure increase for each 6 mos to maximum of $335. $25 additional for afternoon and night. $25 additional for surgery. Liberal paid annual vacation. 7 paid holidays, 8 hr day and 40 hr wk, Social Security and employer-paid help and life insurance program. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GEN'L STAFF & SUPERVISORY NURSES: Positions offering opportunity for advancement available in 518 bed general hospital. Rotating hrs or permanent afternoon or eve shifts for general staff duty. Also openings for head nurses and supervisory appointments. Education and experience will determine salary. Paid vacation and sick leave, free laundry. 40 hr wk, pleasant working conditions, convenient transportation. Housing available in vicinity. Apply Director of Nursing Service, St. Luke's Hospital, 11311 Shaker Blvd., Cleveland 4, Ohio

GRADUATE NURSES: 40 hr wk, 12 paid holidays, 12 paid vacation days, cumulative sick time (15 days a yr) prevailing salaries paid. Hope Dell, Oldham Rd., Preakness, N.J.

GRADUATE NURSES: Vacancies in all areas of nursing service. Rotating experience within a clinical specialty on request. Opportunity for advancement. Hours arranged to permit part-time study at the university and colleges in this city. Active, progressive teaching hospital with developing opportunities for the professional nurse to participate in new approaches in the medical care of patients. Salary $250-280 per mo (base) depending on qualifications. Differential for night or relief duty.

Full maintenance available at $55 per mo. For information, apply to Director of Nursing, City Hospital, Cleveland 9, Ohio

GRADUATE NURSES: For general duty in 135 bed general hospital. No school, organized medical staff, high quality service, pleasant surroundings, attractive living conditions in nurses' home, good pay. For information write Director of Nursing, John D. Archbold Memorial Hospital, Thomasville, Ga.

GRADUATE NURSES: Positions for those who either have or are willing to obtain Colorado registry. Floor duty, rotating shifts, uniform laundry and meals furnished, 2 weeks paid vacation and 7 days sick leave per year. 35 bed hospital in a growing community. Southwest Memorial Hospital, Cortez, Colo.

GRADUATE NURSES & ASS'T HEAD NURSES: We are not partial to any one of the many fine new automobiles coming off the assembly lines but we do like the slogan of one—"The Forward Look". As a matter of fact, the slogan could apply very well to the Los Angeles County Hospital System. Maybe that's why we like it. We have a superior physical plant—buildings, equipment, facilities—that is tops now, but it is steadily being improved. Just this year a new 200 bed Communicable Disease Building was dedicated. Last year a new Psychiatric Building was dedicated. A new $350,000 Student Nurses Home is in process. Thousands of dollars on new equipments are added each year. But even more important than buildings and equipments is our modern approach to our patients and our nurses. At our hospitals nurses are important people. They receive good pay, Civil Service protection in their jobs, opportunities for advancement and opportunities to learn. There is constant attention to making things better for the nurse, the doctor, the patient. (Several new Nurse Instructors were employed just this year to assist in improvement of patient care and planning and carrying out an organized educational program for all Nursing Service personnel.) That forward look just creeps into everything. Los Angeles is growing rapidly—18,340 new settlers each month. They keep coming because Los Angeles is a wonderful place to live and work. It's a booming, vital city—a city with a forward look. A city for forward-looking nurses. The Los Angeles County Hospital System consists of 6 separate hospitals: A TB hospital in San Fernando Valley and in Long Beach; an 800 bed general hospital in Torrance (one mile from the Pacific Ocean); Rancho Los Amigos containing the largest Polio Center west of the Mississippi; the 200 bed John Wesley County Hospital—a recent acquisition; and the County General Hospital, just about the largest hospital in the world. We have a fine School of Nursing, too. If you care to suggest our school to prospective nurses, we should appreciate it Beginning salary for our nurses is $288 and $319 for Ass't Head Nurses. In addition, there are bonuses for evening and night duty and Communicable Diseases, Psychiatric and TB nursing. All of our nurses do the professional job they were trained to do. Why not write us for further information. Write J. K. McInnis, R.N., Los Angeles County General Hospital, Box 1311, Los Angeles 33, Calif. You won't be sorry that you did.

HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy and old-fashioned warm care of patients with cancer and allied diseases. Teaching and research center offers valuable experience. Adequate staff of top nurses maintained. University-affiliated inservice education, access all NYC university programs. Good basic preparation required, learn specialty here. Staff Nurses, $280-320 Day; $330-370 Eve; $320-360 Nite. 4 wks vacation. 1½ pay for overtime, uniforms laundered, Blue Cross paid by Center. Minimum rotation. Suture nurses, base salary plus ½ pay for on-call hrs. Housing agent helps you locate. Thelma Laird, R.N., Director of Nursing, Memorial Center, 444 E. 68th St., New York 21, N.Y.

INSTRUCTOR: Nursing arts. For complete information write Tulare-Kings Counties Hospital, Springville, Calif.

INDUSTRIAL, OFFICE, CLINIC (a) Courier nurses, stewardesses, air, rail, East, South, West, Overseas. (b) Industrial nurse, represent leading utility company in progressive employee health plan, car provided, salary, expenses, metropolitan area, MW. (c) Office Nurse-Manager, new medical suite of certified internist, 35 hours, attractive salary. RN 2-5 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

MALE NURSES: (a) Senior male nurse, administrative ability, supv. emergency aid men, foreign operation, $8500. (b) Supv., 100-bed penal hosp., near resort area, MW, $400. RN 2-6 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

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NEW YORK CITY HEALTH DEPT: Has vacancies in two entrance level positions for Qualified Public Health Nurse and Registered Nurse. Qualified Public Health Nurse Salary $4000, immediate appointment on a provisional basis. Permanent appointment with increases up to $5080, 37 hr wk, liberal vacation and personnel policies, pension rights, in-service training, promotional opportunities. Generalized service including maternal and child care, school health and communicable disease control. Registered Nurse Salary $3500-$3980. Opportunity for registered nurses seeking public health qualifications. Immediate appointment, 37 he wk, liberal personnel policies. Applicants must be able to matriculate for public health nursing courses at university. Applicants (except New York State Veterans) must not have reached 36th birthday. Write or call the New York City Dept. of Health, 125 Worth St., New York 13, N.Y.

NURSE: Registered, for day duty in 230 bed private psychiatric hospital. $250-$280 monthly. 5 day week, vacations and sick leave, 7 paid holidays. Write Personnel Office, Box 467, Amityville, N.Y.

NURSE ANESTHETIST: Two vacancies as of January 1, 1956. Salary range $4050-$5170. 1000 bed public general hospital. Also teaching hospital. Write Superintendent, Edward J. Meyer, Memorial Hospital, 462 Grider St., Buffalo 15, N.Y.

NURSE ANESTHETIST: City of 15,000, 30 mins from city of one-half million. Salary $450 and maintenance. Write P.O. Box 403, McKinney, Tex.

NURSES: 34 bed modern hospital in Southern Colorado. City population 4500. 40 hr wk. 2 wks pd vacation, 14 day accumulative paid sick leave, 2 pd holidays. Social Security benefits, semi-annual raises, Blue Cross & Blue Shield optional, meals, laundry furnished. $10 for night duty. Starting salary $250 per mo. Contact Superintendent, Community Hospital, Monte Vista, Colo.

NURSES: General hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: R.N.'s, all shifts. Large hospital in Brooklyn, N.Y. Good salary and working conditions. Quarters available. Box JCD-2 c/o R.N. Magazine, Oradell, N.J.

NURSES: 150 bed community hospital in small village, 1 hr from New York. O.R. $280 less $25 for meals and laundry, $30 for room if desired. General duty $260 same deductions. $20 additional for p.m. shift. 5 day 40 hr. wk. 3 wk vacation, 11 paid holidays, liberal policies. Within walking distance to swimming, bowling and horseback riding. Northern Westchester Hospital, Mt. Kisco, N.Y.

NURSES: 1 Asst. Dir. N.S., salary $361-426, 1 Head Nurse for Surgery, $293-361, 1 Supervisor Coordinate Surgery C.S.R. and Emergency Room, $325-401. Registered Staff Nurses for days, P.M. & night services, $278-325 with $10 for p.m., nights. $10 for TB, Isolation, Pediatrics, N.P. & Surgery. 15 paid working days vacation after 1 year. 15 paid working days sick time accruable to 90 days, 11 paid holidays, 40 hr wk. Write Director Nursing Service, Monterey County Hospital, P.O. Box 1611, Salinas, Calif.

NURSES: General duty, operating room and emergency room for 150 bed hospital. Apply to Director of Nurses, St. Mary's Hospital, West Palm Beach, Fla.

NURSES: Top salary. Openings on research wards in a well-known N.Y. hospital for graduate nurses with N.Y. State License. Staff nurses, $316.66 per mo; Ass't head nurses, $340 per mo; Supervisors, $416.66 per mo. All required to rotate shifts when necessary. $50 monthly supplement for evening duty, $40 monthly supplement for night duty (no monthly supplement for supervisors). Please submit complete resume of training and experience to Dr. Joseph H. Burchenal, c/o Sloan-Kettering Institute, 410 E. 68th st., New York, N.Y.

NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSES-MEN & WOMEN-GENERAL STAFF: 40 hr wk, 8 hr day, rotating day, evening and night duty. Salary $282 per mo, plus laundering of uniforms, meals on duty, inside maintenance optional with suitable deductions. $20 per mo additional for evening duty, $15 per mo additional for night duty, $20 per mo additional for tuberculosis, psychiatric and contagion duty, $180 yearly increment, liberal sick leave, vacation, 10 holidays, pension plan, advancement opportunities. Pleasant Westchester County suburban

rural environment, easily accessible New York City. Write or telephone Director of Nursing, Grasslands Hospital, Valhalla, N.Y. LYric 2-8500.

OBSTETRICAL NURSES: Openings for Supervisor, Asst Supervisor. Immediate need for staff in 30 bed unit, averaging 100 deliveries per mo. Starting salary $255 with 6 mo and 1 yr merit increases, yearly thereafter. Special considerations given for experience and qualifications. $10 differential for 3-11 and 11-7. Good personnel policies, rooms available $20 per mo. Write Director Nursing Service, Memorial Hospital, Casper, Wyo.

OFFICE NURSE: Small clinic in West Texas. Mild, dry climate, suitable for arrested tbc, bronchitis or asthma. Salary open. W. O. Rehmeyer, M.D., Box 267, Monahans, Tex.

OPERATING ROOM NURSES: For Florida Tuberculosis Hospital. 40 hr wk, liberal sick leave and vacation, pension plan, attractive modern residence, rapidly developing program, wonderful climate, 5 minutes from beach. Write Director of Nursing, Southeast Florida Tuberculosis Hospital, Lantana, Fla.

OPERATING ROOM NURSES: New 50 bed general hospital thriving village Catskill Mountains. Gross starting salary $270 mo. full maintenance available $10.50 week, other benefits. Apply Supt. Nurses, Margaretville Hospital, Margaretville, N.Y. Telephone 0501

OPERATING ROOM NURSES: Immediate appointments. 511 bed newly enlarged and finely equipped hospital. 10 operating rooms now completed. Northeastern Ohio stable "All American City" of 120,000. In center of area of recreational, industrial and educational friendly activities. Living cost reasonable. Within pleasant driving distance advantages of metropolitan Cleveland, Columbus and Pittsburgh. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

OPERATING ROOM NURSES: For 200 bed hospital. Openings for Ass't Supervisor and Staff. Minimum starting salary $255. 40 hr work wk. Special considerations given for experience and qualifications. $20 per mo for call. Average call 2 nights per wk. Good personnel policies, rooms available $20 per mo. Write Director of Nursing Service, Memorial Hospital, Casper, Wyo.

OPERATING ROOM NURSES: 300 bed hospital, 40 hr wk, all cash salary, bonus for on-call, special consideration for experience and advanced preparation, Social Security and Retirement Plan. Apply Director of Nursing, Mercer Hospital, Trenton, N.J.

OPERATING ROOM NURSES—AT MEDICAL CENTER: Start $270 for 40 hr wk, increases at 6 mos, 1 yr and 2 yrs, overtime premium pay, paid vacation, 6 paid holidays, sick leave, free medical services, Social Security. We pay hospitalization insurance, life insurance, retirement annuity. Apply Personnel Director, Rochester Methodist Hospital, Rochester, Minn.

OPERATING ROOM SUPERVISOR: Large hospital in Brooklyn, N.Y. Salary open. Quarters available. Write Box JCD-1 c/o R.N. Magazine, Oradell, N.J.

PEDIATRICS, STAFF & OPERATING ROOM NURSES: New 104 general hospital, latest equipment, ideal location, banks of St. Joseph River, heart of the Fruitbelt, Lake Michigan shores. Living accommodations available. Jr. College in area. 2 hrs from Chicago. 40 hr wk, basic salary $260, shift bonus, good personnel policies, friendly community. For details write Nursing Director, Memorial Hospital, St. Joseph, Mich.

PEDIATRICS TEACHING SUPERVISOR: Position open, 275 bed, accredited hospital school of nursing. Degree and experience preferred. Liberal salary, 5 day wk, Social Security, 3 wks vacation, 6 holidays, 14 day sick leave. Apply Director of Nurses, Lima Memorial Hospital, Lima, Ohio

PROFESSIONAL NURSES: For Operating Rooms, Emergency Room, Medical-Surgical, Pediatrics, Psychiatry, Orthopedics, Urology. Salary and personnel policies comparable to other hospitals in area. Teaching hospital 6 blocks from Teachers College, Columbia University. Write Director of Nursing, Box K, St. Luke's Hospital, New York 25, N.Y.

PSYCHIATRIC NURSE: R.N. for 85 bed private psychiatric hospital. Baltimore suburbs. Live on grounds. Salary plus maintenance. Pleasant modern environment. Give background and experience. Dr. Taylor, Taylor Manor, Ellicott City, Md.

PUBLIC HEALTH NURSES: $360-$417. Must possess a valid California Certificate of Registration as PHN. $378 to start desert areas. Write San Bernardino County Personnel Dept., 236 3rd St., San Bernardino, Calif.

PUBLIC HEALTH: (a) Supv., coastal city, 15,000, South America, free transportation, $6000. (b) Supv. and head nurse, outstanding American company, foreign operation, $9200, $8580 respectively. (c) Asst. Prof., teach personal, community hygiene to freshman women, leading univ. E., $500 month. (d) Staff, local health unit, ideal Arizona location, $4500. RN 2-7 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

PUBLIC HEALTH NURSING STAFF POSITIONS: Official Agency, northern California, rural, generalized program. Requirements: California registration and California Public Health Nurse Certificate. Salary $332 to $415 in 5 yrs. Car furnished. Write Humboldt-Del Norte County, Dept. of Public Health, 805 Sixth St., Eureka, Calif.

R.N.'S: $230 per mo plus maintenance, 5 day week, usual holidays and vacation. License by reciprocity obtainable for most states. 260 bed chronic disease sanitarium. Apply Joseph O. Smigel, M.D., Medical Director, Pinehaven Nursing Home & Sanitarium, Inc., Pinewald, N.J.

R.N.'s: For modern 23 bed hospital. Nurses' Home with full maintenance furnished. Salary open. Write George M. Owens, Adm., Hudspeth Memorial Hospital, Sonora, Tex., or call collect 24441.

REGISTERED NURSE: For general duty in 24 bed hospital. Good working conditions with room and board if desired. Apply to C. E.

White, Administrator, Grayson County War Memorial Hospital, Leitchfield, Ky.

REGISTERED NURSE: 50 bed tuberculosis hospital in Indiana College town. Salary $325 per mo, excellent working conditions. Liberal vacation and sick leave. Address applications to Superintendent, Smith-Esteb Hospital, Richmond, Ind.

REGISTERED NURSES: 3. New, modern 60 bed hospital. Salary $285 plus full maintenance. Town population 9000. Write Administrator, Winkler County Hospital, Kermit, Tex. Please give references.

REGISTERED NURSES: 310 bed general hospital affiliated with U. of Ore. Med. School. Staff nurses basic salary $260 with 5 annual increases up to $322. Ass't Head Nurse basic salary $276 to $344, head nurse $296 to $370. Advancement on promotional basis. Full time evening and night nurses are given ass't head nurse classification.

REGISTERED NURSES: For supervision and staff nursing in new and modernly equipped 93 bed general hospital in southeastern New Mexico. Beginning staff salary $250, supervision $275. Position open for night supervisor $335 per mo. Liberal personnel policies. Write Director of Nurses, Eastern New Mexico Medical Center, Roswell, N.M.

REGISTERED NURSES: For Veterans Administration Hospital, Fort Harrison, Montana, located 3 miles from Helena, the Capitol. 262 bed GM&S hospital. Minimum annual salary $4025 with yearly increases, other salaries dependent upon professional qualifications. Personnel policies provide 40 hr wk, 30 days vacation and 15 days sick leave accrual yearly plus 8 days legal holidays. Federal retirement system coverage, federal group employees life insurance plan and Blue Shield available. Uniform allowances and laundry provided. Nonhousekeeping quarters available. U.S. Citizenship required. Contact Chief, Nursing Service, VAC, Fort Harrison, Mont.

REGISTERED NURSES: People work and save their pennies for years in order to retire and live in Bishop. You can come now. The Northern Inyo Hospital needs registered nurses. Hospital is small, modern, well-equipped. Write Northern Inyo Hospital, Bishop. Calif.

REGISTERED NURSES: All shifts, eve. supervisor 3-11, night 11-7. Good salary. Living quarters available. Apply Dobbs Ferry (N.Y.) Hospital, Dobbs Ferry, N.Y.

REGISTERED NURSES: For general duty and supervisors in modern 58 bed hospital located in beautiful resort area on the shores of Lake Michigan. Excellent salaries with liberal personnel policies. $15 differential for 3-11 and 11-7 shifts. Apply Director of Nurses, The Grand Haven Municipal Hospital, Grand Haven, Mich.

REGISTERED NURSES: Immediate openings in 250 bed general hospital on day and evening shifts. Minimum salary $305 with $20 differential for evening OB and OR. Holidays, vacations, prepaid hospitalization and insurance. Apply to Director of Nurses, Mercy Hospital, Sacramento, Calif.

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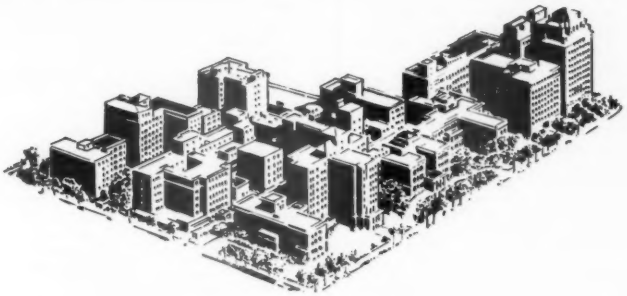

There's a team working here . . .

doctor, nurse, dietitian, technician, administrator—each with his own special skill and function working with the other, as a single unit with the single purpose of patient care at the highest degree.

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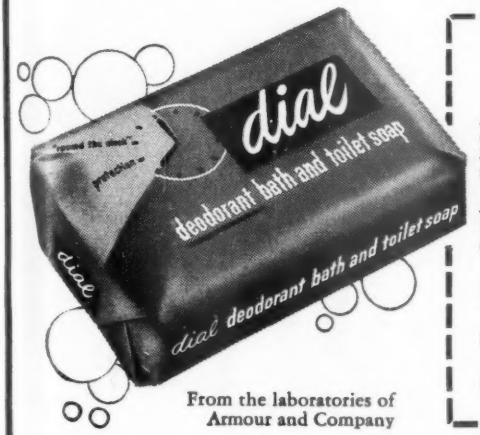

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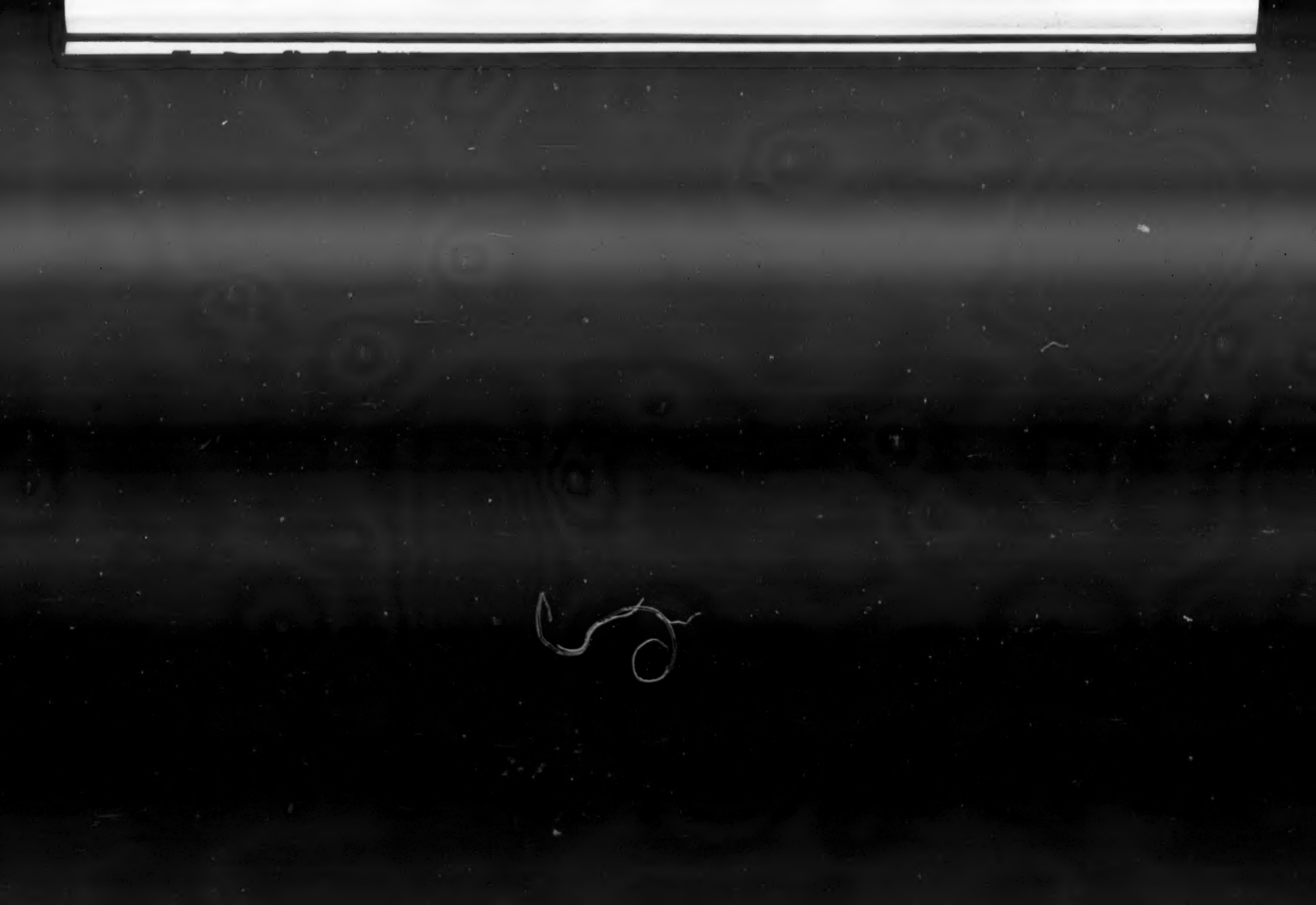

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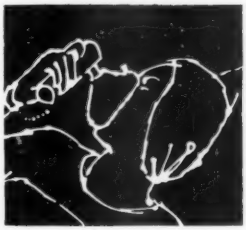

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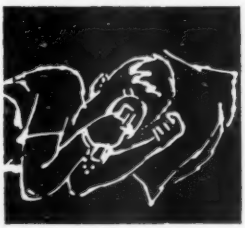

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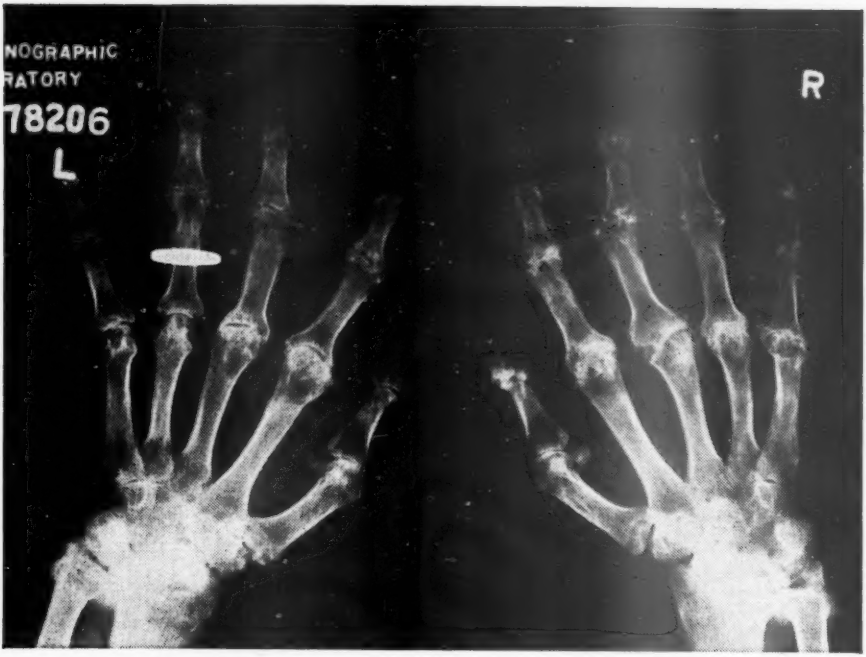

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